सन २०२६-२७ करिता कार्यरत व सेवानिवृत्त राज्य शासकीय अधिकारी/कर्मचारी आणि कार्यरत व सेवानिवृत्त अखिल भारतीय सेवेतील अधिकारी यांचे करिता वैद्यकीय प्रतिपूर्तीची विमाछत्र योजनेच्या नुतनीकरणाबाबत...

महाराष्ट्र शासन

वित्त विभाग

शासन निर्णय क्रमांक संकीर्ण-२०१४/प्र.क्र.४०/भाग-२/कोषा प्रशा-४

मादाम कामा मार्ग, हुतात्मा राजगुरु चौक,
मंत्रालय, मुंबई ४०० ०३२.
दिनांक :- १४ जुलै, २०२६

वाचा : (१) शासन निर्णय, क्रमांक संकिर्ण-२०१४/प्र.क्र.४०/२०१४/कोषा प्रशा-४, दि.०९.०७.२०१४.
(२) शासन निर्णय, क्रमांक संकिर्ण-२०१४/प्र.क्र.४०/२०१४/कोषा प्रशा-४, दि.२५.०६.२०१५.
(३) शासन निर्णय, क्रमांक संकिर्ण-२०१४/प्र.क्र.४०/२०१४/ कोषा प्रशा-४, दि.२८.०६.२०१६.
(४) शासन निर्णय, क्रमांक संकिर्ण-२०१४/प्र.क्र.४०/भाग-१/२०१४/कोषा प्रशा-४, दि.१७.०७.२०१७.
(५) शासन निर्णय, क्रमांक संकिर्ण-२०१४/प्र.क्र.४०/भाग-१/कोषा प्रशा-४, दि.१६.०७.२०१८.
(६) शासन निर्णय, क्रमांक संकिर्ण-२०१४/प्र.क्र.४०/भाग-१/कोषा प्रशा-४, दि.१९.०७.२०१९.
(७) शासन निर्णय, क्रमांक संकिर्ण-२०१४/प्र.क्र.४०/भाग-१/कोषा प्रशा-४, दि.१३.०७.२०२०.
(८) शासन निर्णय, क्रमांक संकिर्ण-२०१४/प्र.क्र.४०/भाग-१/कोषा प्रशा-४, दि.१६.०७.२०२१.
(९) शासन निर्णय, क्रमांक संकिर्ण-२०१४/प्र.क्र.४०/भाग-१/कोषा प्रशा-४, दि.२१.०७.२०२२.
(१०) शासन निर्णय, क्रमांक संकिर्ण-२०१४/प्र.क्र.४०/भाग-१/कोषा प्रशा-४, दि.२४.०७.२०२३.
(११) शासन निर्णय, क्रमांक संकिर्ण-२०१४/प्र.क्र.४०/भाग-२/कोषा प्रशा-४, दि.२३.०७.२०२४
(१२) शासन निर्णय क्रमांक संकिर्ण-२०१४/प्र.क्र.४०/भाग-२/कोषा प्रशा -४, दि.१८.०७.२०२५.
(१३) शासन निर्णय शुद्धीपत्रक क्र.संकिर्ण-२०१४/प्र.क्र.४०/भाग -२/ कोषा प्रशा-४, दि.११.०९.२०२५.

प्रस्तावना-

उपरोक्त “वाचा” मधील अनुक्रमांक १ येथील शासन निर्णयान्वये, कार्यरत व सेवानिवृत्त राज्य शासकीय अधिकारी/कर्मचारी आणि अखिल भारतीय सेवेतील कार्यरत व सेवानिवृत्त अधिकारी तसेच दि.३०.०६.२०११ नंतर सेवानिवृत्त झालेले शासकीय अधिकारी/कर्मचारी व कुटूंब निवृत्तीवेतनधारक यांचेकरिता गटविमा तत्वावर आधारित वैद्यकीय प्रतिपूर्तीची विमाछत्र योजना सन २०१४-१५ पासून लागू करण्यात आली आहे. उपरोक्त वाचा मधील अनुक्रमांक २ ते १३ येथील शासन निर्णयांन्वये सदर योजनेला वेळोवेळी मुदतवाढ देण्यात आलेली आहे. सद्यस्थितीत दि.२५.०७.२०२६ ते दि.२४.०७.२०२७ या कालावधीसाठी सदर योजनेचे नुतनीकरण करण्याची बाब शासनाच्या विचाराधीन होती.

शासन निर्णय

कार्यरत व सेवानिवृत्त अधिकारी/कर्मचारी आणि अखिल भारतीय सेवेतील कार्यरत व सेवानिवृत्त अधिकारी यांचेकरिता सुरु असलेल्या वैद्यकिय प्रतिपूर्तीच्या विमाछत्र योजनेचे दि.२५.०७.२०२६ ते दि.२४.०७.२०२७ या कालावधीसाठी नुतनीकरणास मान्यता देण्यात येत आहे.

प्रस्तुत वैद्यकीय प्रतिपूर्तीची विमाछत्र योजना कार्यरत आणि सेवानिवृत्त अधिकारी/कर्मचारी तसेच अखिल भारतीय सेवेतील अधिकारी यांना सक्तीची राहणार नसून, स्वेच्छेने आवश्यक तो वार्षिक हप्ता भरून संबंधित अधिकारी / कर्मचारी/ निवृत्तीवेतन धारक या योजनेमध्ये सहभागी होऊ शकतील. तसेच या योजनेत केवळ दि.१ जुलै, २०२६ ते दि.३० जून, २०२७ या कालावधीत सेवानिवृत्त झालेले / होणारे अधिकारी / कर्मचारी आणि अखिल भारतीय सेवेतील अधिकारी स्वेच्छेने आवश्यक तो वार्षिक हप्ता भरुन या योजनेमध्ये सहभागी होण्यास पात्र ठरतील. त्याचप्रमाणे योजनेमध्ये गतवर्षी समाविष्ट असलेले सर्व सदस्य नुतनीकरण करण्यासाठी पात्र ठरतील.

२. सन २०२५-२६ मध्ये सदर योजनेंतर्गत विमा कंपनीकडे एकूण विमा हप्ता रक्कम रू.१९.०४ कोटी जमा झाला आहे. तसेच दिनांक ११.०६.२०२६ पर्यंत Incurred Claim Ratio ९६% इतका झाला आहे. अद्याप पॉलिसीची मुदत दिनांक २४.०७.२०२६ पर्यंत शिल्लक असल्याने उर्वरित कालावधीत उद्भवणाऱ्या दाव्यांची संभाव्य संख्या विचारात घेता, एकंदरीत Incurred Claim Ratio १००% पर्यंत होण्याची शक्यता विमा कंपनीने वर्तवली आहे.

३. या पार्श्वभूमीवर, कार्यरत व सेवानिवृत्त अधिकारी/कर्मचारी आणि अखिल भारतीय सेवेतील कार्यरत व सेवानिवृत्त अधिकारी यांचेकरिता सुरु असलेल्या वैद्यकिय प्रतिपूर्तीच्या विमाछत्र योजनेचे वयोगट ४६-५८ तसेच सेवानिवृत्त अधिकारी/ कर्मचारी यांचेकरिता विमा हप्त्याचे दर खालील तक्ता “अ” व “ब” मध्ये दर्शविण्यात येत आहेत. जे अधिकारी / कर्मचारी यांचेसाठी सेवानिवृत्तीचे वय ६० वर्षे आहे, त्यांना तक्ता “ब” मधील सेवानिवृत्त अधिकारी / कर्मचारी यांचेसाठी विमा हप्त्यांचे दर (GST सह) लागू राहतील.

तक्ता-(अ)

४६-५८ वर्षे वयोगटातील कार्यरत अधिकारी/कर्मचाऱ्यांसाठी विमा हप्त्याचे दर (GST सह)

अ. क्र .	विमाछत्र रक्कम	फक्त कर्मचारी स्वत:	१+३ (कर्मचारी, कर्मचाऱ्यांची पती/ पत्नी, २ अवलंबित मुले २५ वर्षे वयाच्या मर्यादेत)
	रुपये	विमा हप्ता रुपये	विमा हप्ता रुपये
१	१ लाख	४१५९	२२०७०
२	२ लाख	४४०३	२५६८९
३	३ लाख	५८६९	३५१०३
४	४ लाख	६३५९	३८९४९
५	५ लाख	७९२१	३९६५७
६	८ लाख	१२९६२	७७३४१
७	१० लाख	१४०३६	८७०६६
८	१२ लाख	१५३११	१००९९५
९	१५ लाख	२१३०४	१६३२३७
१०	२० लाख	२५५१७	१७१०११

तक्ता-(ब)

सेवानिवृत्त अधिकारी/कर्मचाऱ्यांसाठी विमा हप्त्याचे दर (GST सह)

अ. क्र.	विमाछत्र रक्कम रुपये	फक्त कर्मचारी स्वत: विमा हप्ता रुपये	१+१ (कर्मचारी, कर्मचाऱ्यांची पती/ पत्नी) विमा हप्ता रुपये
१	१ लाख	१९२३१	३०६७०
२	२ लाख	२७८२०	४४५०३
३	३ लाख	२९९३०	४७३१९
४	४ लाख	३९८१३	६५१९६
५	५ लाख	४२७६९	६९०७५
६	८ लाख	६५८८६	१०६१३२
७	१० लाख	९९०३१	१५८३२३
८	१२ लाख	११६०४०	१८५६७९
९	१५ लाख	१३९६५९	२२३४३९
१०	२० लाख	१७६५०१	२८०२०४

४. वैद्यकीय प्रतिपूर्तीच्या विमाछत्र योजनेमध्ये कार्यरत अधिकारी / कर्मचारी यांच्या करिता वयोगट १८-३५ वर्षे व वयोगट ३६-४५ वर्षे यांच्याकरिता विमा पॉलिसीमध्ये खालील बाबी समाविष्ट आहेत. **(परिशिष्ट-३ – न्यू इंडिया अॅश्यूरन्स कंपनीचे युवा भारत पॉलिसी डॉक्युमेंट सोबत जोडले आहे.)**

- योजनेमध्ये समावशेनाचे वय- अधिकारी / कर्मचाऱ्यांसाठी १८ ते ४५ वर्षे आणि त्यांच्या अवलंबित अपत्यांसाठी ९१ दिवस ते २५ वर्षे.
- कुटूंब - १+३ (कर्मचारी, कर्मचाऱ्यांची पती/ पत्नी, २ अवलंबित मुले २५ वर्षे वयाच्या मर्यादेत).
- विमाछत्र रक्कम- रु.५ लाख, रु.१० लाख, रु.१५ लाख, रु.२५ लाख.
- योजनेमध्ये समावेशनासाठी कोणतीही पूर्व वैद्यकीय चाचणी नाही.
- योजनेच्या अटी व शर्तीनुसार वाजवी आणि वैद्यकीयदृष्ट्या आवश्यक खालील खर्चाची प्रतिपूर्ती करण्यात येणार आहे.

a	Room Rent including Boarding, DMO / RMO / CMO / RMP Charges, Nursing (Including Injection / Drugs and Intra venous fluid administration expenses) as provided by the hospital.
	Sum insured of Rs. 5,00,000 /10,00,000/15,00,000 -Single AC room.
	Sum insured of Rs. 25,00,000/50,00,000/75,00,000/ 1,00,00,000- Deluxe AC room.
b	Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU), Intensivist charges, Monitor and Pulse Oxymeter expenses.
c	Associate Medical Expenses; such as Professional fees of Surgeon, Anaesthetist, Consultant, Specialist; Operating Theatre Charges and Procedure Charges such as Dialysis, Chemotherapy, Radiotherapy & similar medical expenses related to the treatment.
d	Cost of Pharmacy and Consumables including Anaesthesia, Blood, Oxygen, Cost of Implants and Medical Devices and Cost of Diagnostics.
e	Pre-Hospitalization Medical expenses up to 60 days prior to the date of admission to the hospital.
f	Post-Hospitalization Medical expenses up to 90 days from the date of discharge from the hospital.

Plan Salient Coverages:

- Hospital Cash benifit
- Cost of Health Check-up
- New Born Baby Cover
- Medical Second Opinion
- Medical Expenses For Organ Transplant
- Coverage for Hazardous Sports, 10% of Sum insured, subject to a maximum of Rs.1,00,000/-
- Road Ambulance Upto Rs.5,000/-.
- Shared Accommodation Benefit.
- Air Ambulance: For SI 5L, 10L & 15L- Rs. 50,000/-; for SI 25 L– Rs. 75,000/-
- Infertility Treatment: For SI 5L, 10L & 15L- Rs. 50,000/-; for SI 25 L– Rs. 75,000/-
- Maternity Coverage: Single Baby- Rs. 25,000/- Twin Babies- Rs. 37,500/-
- Vaccination Charges.
- Pre-Term / Premature Birth.
- Birth Right Benefit.
- Pre-Hospitalization of 60 days.
- Post-Hospitalization of 90 days.
- Expense incurred for Ayurveda, Yoga, Naturopathy, Unani, Siddha, and Homeopathy covered 100% of Sum Insured.
- Coverage for Modern Treatments-

५. १८-३५ व ३६-४५ वर्षे वय असलेल्या अधिकारी/कर्मचाऱ्यांसाठी विमा हप्त्याचे (GST सह) दर खालील तक्ता “क” व “ड” मध्ये दर्शविण्यात येत आहेत.

तक्ता-(क)

१८-३५ वर्षे वयोगटातील कार्यरत अधिकारी/कर्मचाऱ्यांसाठी विमा हप्त्याचे दर (GST सह)

अ .क्र.	विमाछत्र रक्कम	फक्त कर्मचारी स्वत:	१+३ (कर्मचारी, कर्मचाऱ्यांची पती/ पत्नी, २ अवलंबित मुले २५ वर्षे वयाच्या मर्यादेत)
	रुपये	विमा हप्ता रुपये	विमा हप्ता रुपये
१.	५ लाख	१०,६०९	२६,७९४
२.	१० लाख	१२,३८०	३१,३९७
३.	१५ लाख	१४,९७२	३८,०७५
४.	२५ लाख	२०,०५९	५१,२५२

तक्ता-(ड)

३६-४५ वर्षे वयोगटातील कार्यरत अधिकारी/कर्मचाऱ्यांसाठी विमा हप्त्याचे दर (GST सह)

अ. क्र.	विमाछत्र रक्कम	फक्त कर्मचारी स्वत:	१+३ (कर्मचारी, कर्मचाऱ्यांची पती/ पत्नी, २ अवलंबित मुले २५ वर्षे वयाच्या मर्यादेत)
	रुपये	विमा हप्ता रुपये	विमा हप्ता रुपये
१.	५ लाख	१६,४०१	३६,६४१
२.	१० लाख	१९,२७१	४३,११२
३.	१५ लाख	२३,४२३	५२,४४३
४.	२५ लाख	३१,६००	७०,८७१

६. या योजनेतर्गंत समाविष्ट होणाऱ्या अधिकारी/कर्मचारी आणि निवृत्तीवेतनधारक यांना वैद्यकीय चाचणीची पूर्वअट राहणार नाही. तसेच या योजनेत समावेश करतेवेळी अस्तित्वात असलेल्या आजारांनाही विमाछत्र उपलब्ध असेल. **(परिशिष्ट-२ - न्यू इंडिया ॲश्यूरन्स कंपनीच्या पॉलिसी डॉक्युमेंटमधील अ.क्र.४.१ चे कृपया अवलोकन व्हावे.)**

७. जे अधिकारी/कर्मचारी विमाछत्र योजना कालावधीमध्ये सेवानिवृत्त होणार आहेत, परंतु सदर योजनेमध्ये समाविष्ट होऊ इच्छित नाहीत, अशा अधिकारी/कर्मचाऱ्यांकडून सदर योजनेमध्ये भविष्यातही समाविष्ट न होण्याबाबतचे घोषणापत्र (Opting Out Declaration) **परिशिष्ट-१** मधील विहीत नमून्यात घेण्याची दक्षता संबंधित आहरण व संवितरण अधिकारी यांनी घ्यावी. सदरचे घोषणापत्र सेवानिवृत्तीवेतन प्रकरणासोबत कोषागार कार्यालयास सादर करावे.

८. सदर योजनेमध्ये नव्याने समाविष्ट होऊ इच्छिणाऱ्या सदस्यांना ९० दिवसांचा प्रतिक्षा कालावधी असेल. तसेच सोबत जोडलेल्या परिशिष्ट-२ मधील आजारांकरिता योजनेमध्ये नव्याने समाविष्ट होऊ इच्छिणाऱ्या सदस्यांना १८ महिन्यांचा प्रतिक्षा कालावधी असेल. तसेच सदर आजारांकरिता **२०%** Co pay लागू राहील.

९. योजनेमध्ये गतवर्षी समाविष्ट असलेल्या सदस्यांनी चालू वर्षी कोणत्याही परिस्थितीत ३० दिवसांच्या आत विमा हप्त्याचा भरणा करुन योजनेचे नुतनीकरण करणे, ही विमा धारकाची वैयक्तिक जबाबदारी राहील. ३० दिवसांच्या मुदतीनंतर योजनेचे नुतनीकरण केल्यास असा सभासद योजनेमध्ये नव्याने समाविष्ट झाल्याचे समजले जाईल. **(याकरिता आहरण व संवितरण अधिकारी अथवा कोषागार अधिकारी जबाबदार असणार नाहीत.)**

१०. ज्या रुग्णालयांत दि न्यु इंडिया ॲश्युरन्स कंपनी लि. यांचे PPN (Preferred Provider Network) आहे, तेथे रोकडरहीत (Cashless) सुविधा उपलब्ध असेल. PPN रुग्णालया व्यतिरिक्त अन्य रुग्णालयात उपचार घेतल्यास वैद्यकिय प्रतिपूर्ती उपलब्ध राहील. जेथे PPN रुग्णालय उपलब्ध आहेत, तेथे केवळ PPN पॅकेजेस प्रतिपूर्तीसाठी ग्राहय धरली जातील.

स्पष्टीकरण:- अ) विमा धारकास कोणत्याही PPN रुग्णालयामध्ये उपचार घेण्याची मुभा असेल, तथापि, प्रतिपूर्ती ही विमा कंपनीच्या PPN पॅकेजेसच्या दराप्रमाणे दिली जाईल. रुग्णालयाचे दर व PPN दर यातील फरक विमा धारकाने सोसावयाचा आहे.

ब) PPN बाहेरील रुग्णालयामध्ये उपचार घेण्याचे स्वातंत्र्य विमा धारकास असेल, तथापि, अशा प्रकरणी विमा कंपनीच्या प्रचलित धोरणानुसार रुग्णालयाची अर्हता तपासून कंपनी दावा पारित करेल.

११. सदर शासन निर्णयाशी विसंगत नसतील, अशा मागील वर्षांच्या योजनेतील सर्व अटी व शर्ती सन २०२६-२७ साठीच्या योजनेकरिताही लागू राहतील.

१२. मागील वर्षी दाव्याच्या प्रतिपूर्तीचा लाभ घेतलेले जे सदस्य चालू वर्षी नुतनीकरण करणार नाहीत, त्यांना या योजनेत भविष्यात समाविष्ट होण्यास कायमस्वरूपी प्रतिबंधित करण्यात येईल.

१३. विमा कंपनीच्या असे निर्देशनास आले आहे की, रुग्णालयात दाखल झाल्यानंतर विमा धारकाकडून त्याची माहिती त्रयस्थ प्रशासकास (TPA) विलंबाने दिली जाते. त्यामुळे दाव्याची सत्यता पडताळणी करण्यास अडचणी येतात. सबब, विमा धारकांनी प्रतिपूर्तीकरिता दावा सादर करतांना दाव्याची सूचना त्रयस्थ प्रशासकास (TPA) रुग्णालयात दाखल झाल्याच्या दिनांकापासून ७२ तासांच्या आत न दिल्यास दाव्यावर **१०% "Co Pay"** लागु राहील.

१४. विमाधारकाने आंतररुग्ण कालावधी समाप्त झाल्यानंतर (Date of Discharge) ३० दिवसांच्या आत विमा दावा विमा कंपनीस सादर करणे आवश्यक राहील. विमा दावा सादर करण्यास ३१ ते ५० दिवसांचा विलंब झाल्यास दाव्यावर २०% "Co Pay" लागू राहील. विमा दावा सादर करण्यास ५१ ते ७५ दिवसांचा विलंब झाल्यास दाव्यावर २५% "Co Pay" लागू राहील. विमा दावा सादर करण्यास ७६ ते १०० दिवसांचा विलंब झाल्यास दाव्यावर ३०% "Co Pay" लागू राहील व विमा दावा सादर करण्यास १०० दिवसांपेक्षा जास्त विलंब झाल्यास विमा दावा नाकारण्यात येईल.

१५. वयोगट ४५-५८ वर्षे तसेच निवृत्तीवेतनधारक अधिकारी /कर्मचारी यांचेबाबतीत विमाछत्र रक्कम रु.१० लाख ते रु.२० लाख मधील विमाधारकांना रुग्णालयातील वास्तव्य खर्च (Room Rent) यासाठी अधिकतम मर्यादा **(Capping)** खालीलप्रमाणे असतील.

विमाछत्र रक्कम	सर्वसाधारण वास्तव्याकरिता	अतिदक्षता कक्षातील वास्तव्याकरिता
रु.१० लाख व १२ लाख	आश्वासित रकमेच्या १% व कमाल रु.८,०००/- च्या मर्यादेत प्रतिदिन	आश्वासित रकमेच्या २% व कमाल रु.१६,०००/- च्या मर्यादेमध्ये प्रतिदिन
रु. १५ लाख	आश्वासित रकमेच्या १% व कमाल रु.१०,०००/- च्या मर्यादेत प्रतिदिन	आश्वासित रकमेच्या २% व कमाल रु.२०,०००/- च्या मर्यादेत प्रतिदिन
रु.२० लाख	आश्वासित रकमेच्या १% व कमाल रु.१५,०००/- च्या मर्यादेत प्रतिदिन	आश्वासित रकमेच्या २% व कमाल रु.३०,०००/- च्या मर्यादेमध्ये प्रतिदिन

१६. विमा पॉलिसीचे नुतनीकरण करताना, विमा हप्त्याचे प्रदान विमा कंपनीस **https://easypay.axisbank.co.in/easyPay/makePayment?mid=NTg4MzQ%3D** या लिंकद्वारे करणे बंधनकारक असणार आहे. सदर पेमेंट लिंकचा वापर करुन NEFT/RTGS/UPI

अथवा Credit Card द्वारे विमा हप्त्याचे प्रदान करता येऊ शकते. **मात्र सदर लिंकद्वारे Debit card द्वारे विमा हप्ता प्रदान करता येऊ शकणार नाही.**

१७. विमाछत्र योजनेमध्ये नुतनीकरणासाठी उपरोक्त लिंक संबंधित विमाधारकास SMS द्वारे भ्रमण दूरध्वनीवर (Mobile Phone) अथवा ई-मेलद्वारे प्राप्त होणार आहे, अशा प्रकारची लिंक प्राप्त न झाल्यास The New India Assurance Co. Ltd. यांचेशी ९१३७८४६७६६ या क्रमांकावर संपर्क साधावा.

१८. नवीन नोंदणीसाठी योजनेमध्ये समाविष्ठ होऊ इच्छिणाऱ्या अधिकारी/कर्मचाऱ्यांनी खालील दिलेल्या गुगल फॉर्म वर अचूक माहिती विमा कंपनीस सादर करावयाची आहे.

https://docs.google.com/forms/d/e/1FAIpQLSfbSX5g_NHgnAWxOW_hkl5kVarBCFOXgxM58Gr4sPkHAqb7pA/viewform?usp=dialog

१९. सर्व विवाहीत कर्मचाऱ्यांनी सदर योजनेमध्ये नवीन नोंदणी व नूतनीकरण करतांना १+३ या पर्यायाचा अवलंब करणे बंधनकारक आहे.

२०. विमाछत्र योजनेमधील वैद्यकीय दाव्यांसंदर्भात अथवा रोकडरहीत (Cashless) सुविधेबाबत कर्मचारी/ अधिकारी/निवृत्तीवेतनधारक यांना काही शंका असल्यास MD India (TPA-त्रयस्थ प्रशासक) यांचेशी Toll Free No.१८००-२०९-७७७७ अथवा ९३७०५५०४४९ या भ्रमणध्वनी क्रमांकावर संपर्क साधता येईल. तसेच विमा हप्ता भरण्यासंदर्भात काही शंका असल्यास The New India Assurance Co. Ltd. यांचेशी ९१३७८४६७६६ या क्रमांकावर संपर्क साधता येईल.

२१. सदर योजनेच्या सविस्तर कार्यपध्दतीबाबत संचालक (लेखा व कोषागारे), मुंबई यांनी निर्गमित केलेल्या सूचना https://mahakosh.maharashtra.gov.in या संकेतस्थळावरील Circular & Order या पर्यायाखाली उपलब्ध असतील.

सदर शासन निर्णय महाराष्ट्र शासनाच्या www.maharashtra.gov.in या संकेतस्थळावर उपलब्ध करण्यात आला असून त्याचा संगणक सांकेतांक क्र. २०२६०७१४१६३१०००८०५ असा आहे. हा शासन निर्णय डिजीटल स्वाक्षरीने साक्षांकित करुन काढण्यात येत आहे.

महाराष्ट्राचे राज्यपाल यांच्या आदेशानुसार व नांवाने,

ASHOK GULAB CHAUDHARI

Digitally signed by ASHOK GULAB CHAUDHARI
DN: c=IN, o=GOVERNMENT OF MAHARASHTRA, ou=FINANCE DEPARTMENT, 2.5.4.20=3A31F1E61A49658347833C8C22A09CB8141A51CF08DA760FD5E2A1B3C1769153, postalCode=400032, st=Maharashtra, serialNumber=3E9FA04602558FF79EC2FCB3553E7DA28D75751FAA9AA5AA2261D3E69F011558, cn=ASHOK GULAB CHAUDHARI
Date: 2026.07.14 16:40:42 +05'30'

(अशोक चौधरी)
कार्यासन अधिकारी, महाराष्ट्र शासन

सहपत्र - परिशिष्ट-१, परिशिष्ट-२ व परिशिष्ट-३

प्रत,

१. मा.राज्यपाल यांचे सचिव.
२. मा.मुख्यमंत्री यांचे सचिव / प्रधान सचिव / अपर मुख्य सचिव.

३. मा.उप मुख्यमंत्री (नगर विकास व गृह निर्माण) यांचे सचिव / प्रधान सचिव.
४. मा.उप मुख्यमंत्री (वित्त व नियोजन आणि उत्पादन शुल्क) यांचे सचिव / प्रधान सचिव.
५. सर्व मा.मंत्री व मा.राज्यमंत्री यांचे खाजगी सचिव.
६. मा.विरोधी पक्षनेता, विधान परिषद, महाराष्ट्र विधानमंडळ सचिवालय,मुंबई.
७. सर्व सन्माननीय विधानसभा / विधान परिषद व संसद सदस्य.
८. सर्व अपर मुख्य सचिव / प्रधान सचिव / सचिव, मंत्रालयीन प्रशासकीय विभाग.
९. सर्व मंत्रालयीन प्रशासकीय विभागांच्या अधिनस्त असलेल्या सर्व विभाग प्रमुख, प्रादेशिक कार्यालय प्रमुख, आणि कार्यालय प्रमुख.
१०.प्रबंधक, मूळ न्यायालय शाखा, उच्च न्यायालय, मुंबई.
११.प्रधान महालेखापाल (लेखा परीक्षा)- १, महाराष्ट्र, मुंबई.
१२.प्रधान महालेखापाल (लेखा व अनुज्ञेयता)-१, महाराष्ट्र, मुंबई
१३.महालेखापाल (लेखापरीक्षा)-२, महाराष्ट्र, नागपूर
१४.महालेखापाल (लेखा व अनुज्ञेयता)-२, महाराष्ट्र, नागपूर.
१५.आयुक्त, आयकर (TDS) चर्नीरोड, मुंबई ४००००२.
१६.आयुक्त, आयकर (TDS) सिव्हील लाईन*, नागपूर ४४४००१.
१७.प्रबंधक, उच्च न्यायालय (अपील शाखा) मुंबई.
१८. सचिव, महाराष्ट्र लोकसेवा आयोग, मुंबई.
१९.सचिव, महाराष्ट्र विधीमंडळ सचिवालय, मुंबई.
२०.प्रबंधक, लोक आयुक्त व उपलोक आयुक्त यांचे कार्यालय, मुंबई.
२१.प्रबंधक, महाराष्ट्र प्रशासकीय न्यायाधिकरण, मुंबई.
२२.मुख्य माहिती आयुक्त, महाराष्ट्र राज्य, मुंबई.
२३.विशेष आयुक्त, महाराष्ट्र सदन, कोपर्निकस रोड, नवी दिल्ली.
२४.सर्व विभागीय आयुक्त.
२५.सर्व जिल्हाधिकारी.
२६.सर्व जिल्हा परिषदांचे मुख्य कार्यकारी अधिकारी.
२७.संचालक, लेखा व कोषागारे, महाराष्ट्र राज्य, मुंबई.
२८. संचालक, स्थानिक निधी लेखापरीक्षा, नवी मुंबई.
२९.सह संचालक,लेखा व कोषागारे,कोकण / पुणे / नाशिक / छत्रपती संभाजी नगर / अमरावती / नागपूर.
३०.सह संचालक,स्थानिक निधी लेखा, कोकण / पुणे / नाशिक / छत्रपती संभाजी नगर / अमरावती / नागपूर.
३१.अधिदान व लेखा अधिकारी, अधिदान व लेखा कार्यालय मुंबई.
३२.निवासी लेखापरीक्षा अधिकारी, मुंबई.
३३.वरिष्ठ जिल्हा कोषागार अधिकारी, ठाणे / पुणे / नाशिक / छत्रपती संभाजी नगर / अमरावती / नागपूर.
३४.सर्व जिल्हा कोषागार अधिकारी.
३५.सर्व उप कोषागार अधिकारी.
३६.वित्त विभागातील सर्व कार्यासने.
३७. निवड नस्ती / कोषा प्रशा- ४ कार्यासन.

शासन निर्णय क्रमांक संकीर्ण-२०१४/प्र.क्र.४०/भाग-२/कोषा-प्रशा-४, दि.१४ जुलै,२०२६ सोबतचे सहपत्र

परिशिष्ट-१

घोषणापत्र (Opting Out Declaration)

१. मी, श्री./श्रीम.---

पीपीओ क्र.------------------अन्य वैद्यकीय विमा कंपनी-----------------

---------------- चा सभासद **आहे/नाही**.

२. मी, श्री./श्रीम.---------------------------------- घोषित करतो/करते की, मी राज्य शासनाच्या वैद्यकीय प्रतिपूर्तीच्या विमाछत्र योजनेमध्ये सहभागी होऊ इच्छित नसून भविष्यात देखील या योजनेमध्ये सहभागी होण्याची मागणी करणार नाही.

आपला,

अधिकारी/कर्मचारी यांची
स्वाक्षरी

नाव:-

पदनाम:-

कार्यालयाचे नाव:-

THE NEW INDIA ASSURANCE CO. LTD

Regd. & Head Office: 87, M.G. Road, Fort, Mumbai – 400 001

NEW INDIA FLEXI FLOATER GROUP MEDICLAIM POLICY

1.0 PREAMBLE

Whereas Insured designated in the Schedule hereto has by a proposal and declaration dated as stated in the Schedule which shall be the basis of this Contract and is deemed to be incorporated herein, has applied to THE NEW INDIA ASSURANCE CO. LTD. (hereinafter called the COMPANY) for the insurance herein after set forth in respect of Employees/Members (including their eligible Family Members) named in the Schedule hereto (herein after called the INSURED PERSON) and has paid premium as consideration for such insurance

2.0 DEFINITIONS

STANDARD DEFINITIONS

2.1 **ACCIDENT** is a sudden, unforeseen and involuntary event caused by external, visible and violent means.

2.2 **ANY ONE ILLNESS** means continuous Period of illness and it includes relapse within 45 days from the date of last consultation with the Hospital where treatment may have been taken.

2.3 **AYUSH HOSPITAL** is a Healthcare facility wherein medical / surgical / para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:

a. Central or State Government AYUSH Hospital or
b. Teaching hospital attached to AYUSH College recognized by the Central Government / Central Council of Indian Medicine / Central Council for Homeopathy; or
c. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:
   i. Having at least 5 in-patient beds;
   ii. Having qualified AYUSH Medical Practitioner in charge round the clock;
   iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
   iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

2.4 **AYUSH DAY CARE CENTRE** means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment

procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner(s) on day care basis without in-patient services and must comply with all the following criterion:

i. Having qualified registered AYUSH Medical Practitioner(s) in charge;
ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;
iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

2.5 **CASHLESS FACILITY** means a facility extended by the insurer to the Insured where the payments, of the costs of treatment undergone by the Insured in accordance with the policy terms and conditions, are directly made to the network provider by the Company to the extent pre-authorization approved.

2.6 **CONDITION PRECEDENT:** Condition Precedent shall mean a policy term or condition upon which the Insurer's liability under the policy is conditional upon.

2.7 **CONGENITAL ANOMALY:** refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.

i. **CONGENITAL INTERNAL ANOMALY** means a Congenital Anomaly which is not in the visible and accessible parts of the body.
ii. **CONGENITAL EXTERNAL ANOMALY** means a Congenital Anomaly which is in the visible and accessible parts of the body

2.8 **DAY CARE CENTRE:** A day care centre means any institution established for day care treatment of illness and/or injuries or a medical setup within a hospital and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified Medical Practitioner AND must comply with all minimum criteria as under:

- Has qualified nursing staff under its employment;
- Has qualified medical practitioner/s in charge;
- Has a fully equipped operation theatre of its own where surgical procedures are carried out;
- Maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

2.9 **DAY CARE TREATMENT** refers to medical treatment or Surgery which are:

- Undertaken under General or Local Anesthesia in a Hospital/Day Care Centre in less than 24 hours because of technological advancement, and
- Which would have otherwise required a hospitalization of more than 24 hours.

Treatment normally taken on an out-patient basis is not included in the scope of this definition.

2.10 **DENTAL TREATMENT** is treatment carried out by a dental practitioner including examinations, fillings (where appropriate), crowns, extractions and surgery excluding any form of cosmetic surgery / implants.

2.11 **DISCLOSURE TO INFORMATION NORM**: The policy shall be void and all premium paid thereon shall be forfeited to Us in the event of misrepresentation, mis-description or non-disclosure of any material fact.

2.12 **EMERGENCY CARE** means management for an Illness or Injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a medical practitioner to prevent death or serious long-term impairment of the Insured Person's health.

2.13 GRACE PERIOD means specified period of time immediately following the premium due date during which a payment can be made to renew or continue the Policy in force without loss of continuity benefits such as waiting period and coverage of pre-existing diseases. Coverage is not available for the period for which no premium is received.

2.14 HOSPITAL means any institution established for Inpatient Care and Day Care treatment of Illness and / or Injuries and which has been registered as a Hospital with the local authorities under the Clinical Establishment (Registration and Regulation) Act, 2010 or under the enactments specified under the schedule of Section 56(1) of the said act OR complies with all minimum criteria as under:

- has at least 10 inpatient beds, in those towns having a population of less than 10,00,000 and at least 15 inpatient beds in all other places;
- has qualified nursing staff under its employment round the clock;
- has qualified medical practitioner (s) in charge round the clock;
- has a fully equipped operation theatre of its own where surgical procedures are carried out
- maintains daily records of patients and will make these accessible to the Insurance company's authorized personnel.

The term 'Hospital' shall not include an establishment which is a place of rest, a place for the aged, a place for drug-addicts or place for alcoholics, a hotel or a similar place.

2.15 HOSPITALISATION means admission in a Hospital for a minimum period of 24 in patient Care consecutive hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours.

Anti-Rabies Vaccination	Hysterectomy
Appendectomy	Inguinal/Ventral/Umbilical/Femoral Hernia
Coronary Angiography	Lithotripsy (Kidney Stone Removal)
Coronary Angioplasty	Parenteral Chemotherapy
Dental surgery following an accident	Piles / Fistula
Dilatation & Curettage (D & C) of Cervix	Prostate
Eye surgery	Radiotherapy
Fracture / dislocation excluding hairline Fracture	Sinusitis
Gastrointestinal Tract system	Stone in Gall Bladder, Pancreas, and Bile Duct
Haemo-Dialysis	Tonsillectomy,
Hydrocele	Urinary Tract System

OR any other Surgeries / Procedures agreed by TPA/Company which require less than 24 hours hospitalization due to advancement in Medical Technology.

2.16 ILLNESS means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the Policy Period and requires medical treatment.

2.17 INJURY means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent and visible and evident means which is verified and certified by a Medical Practitioner.

i. **Acute Condition** means a disease, Illness or Injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease / Illness / Injury which leads to full recovery.

ii. **Chronic Condition** means a disease, Illness, or Injury that has one or more of the following characteristics

   a. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests
   b. it needs ongoing or long-term control or relief of symptoms
   c. it requires rehabilitation for the patient or for the patient to be special trained to cope with it

d. it continues indefinitely
e. it recurs or is likely to recur

2.18 **INPATIENT CARE** means treatment for which the Insured Person has to stay in a Hospital for more than 24 hours for a covered event.

2.19 **INTENSIVE CARE UNIT (ICU)** means an identified section, ward or wing of a Hospital which is under the constant supervision of a dedicated Medical Practitioner, and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

2.20 **ICU (INTENSIVE CARE UNIT) CHARGES** means the amount charged by a Hospital towards ICU expenses on a per day basis which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.

2.21 **MEDICAL ADVICE** means Any consultation or advice from a Medical Practitioner including the issue of any prescription or repeat prescription.

2.22 **MEDICAL EXPENSES** means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or Injury on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other Hospitals or doctors in the same locality would have charged for the same medical treatment.

2.23 **MEDICALLY NECESSARY** treatment is defined as any treatment, tests, medication, or stay in Hospital or part of a stay in Hospital which

- is required for the medical management of the Illness or Injury suffered by the insured;
- must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
- must have been prescribed by a Medical Practitioner;
- must confirm to the professional standards widely accepted in international medical practice or by the medical community in India.

2.24 **MEDICAL PRACTITIONER** is a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of his license.

Note: The Medical Practitioner should not be the insured or close family members.

2.25 **NETWORK HOSPITAL** means Hospitals enlisted by the Company, TPA or jointly by the Company and TPA to provide medical services to an Insured by a cashless facility.

2.26 **NON-NETWORK HOSPITAL** means any Hospital that is not part of the network.

2.27 **NOTIFICATION OF CLAIM** means the process of intimating a claim to the Company or TPA through any of the recognized modes of communication.

2.28 **PRE-EXISTING DISEASE (PED)** means any condition, ailment, Injury or Illness

a. That is/are diagnosed by a physician within 48 months prior to the effective date of the Policy issued by Us and its reinstatement or

b. For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the Policy or its reinstatement.

2.29 **PRE-HOSPITALISATION MEDICAL EXPENSES** mean Medical Expenses incurred during the period preceding the Insured Person is Hospitalised, provided that:

i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalization was required, and
ii. The Inpatient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.

2.30 **POST-HOSPITALISATION MEDICAL EXPENSES** mean Medical Expenses incurred during the period immediately after the Insured Person is discharged from the hospital provided that:

i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and
ii. The Inpatient Hospitalisation claim for such Hospitalisation is admissible by the Insurance Company.

2.31 **QUALIFIED NURSE** Qualified nurse is a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.

2.32 **REASONABLE AND CUSTOMARY CHARGES** mean the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the Illness / Injury involved.

2.33 **RENEWAL** means the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of all waiting periods.

2.34 **ROOM RENT** means the amount charged by a Hospital for the occupancy of a bed per day (24 hours) basis and shall include associated medical expenses.

2.35 **SUB-LIMIT** means a cost sharing requirement under this policy in which We would not be liable to pay any amount in excess of the pre-defined limit.

2.36 **SURGERY OR SURGICAL PROCEDURE** means manual and / or operative procedure (s) required for treatment of an Illness or Injury, correction of deformities and defects, diagnosis and cure of diseases, relief of suffering or prolongation of life, performed in a Hospital or Day Care Centre by a Medical Practitioner.

SPECIFIC DEFINITIONS

2.37 **AGE** means age of the Insured person on last birthday as on date of commencement of the Policy.

2.38 **ASSOCIATE MEDICAL EXPENSES** means medical expenses such as Professional fees of Surgeon, Anaesthetist, Consultant, Specialist; Anaesthesia, Blood, Oxygen, Operating Theatre Charges and Procedure Charges such as Dialysis, Chemotherapy, Radiotherapy & similar medical expenses related to the treatment.

2.39 **AYUSH TREATMENT** refers to Hospitalisation treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

2.40 **BREAK IN POLICY** means the period of gap that occurs at the end of the existing policy term, when the premium due for renewal on a given policy is not paid on or before the premium renewal date or within 30 days thereof.

2.41 **FLOATER BENEFIT** means the Sum Insured as specified for a particular Insured and the members of his / her family as covered under the policy and is available for any or all the members of his / her family for one or more claims during the tenure of the policy.

2.42 **INSURED PERSON** means person(s) named in the schedule of the Policy.

2.43 **POLICY** means these Policy wordings, the Policy Schedule and any applicable endorsements or extensions attaching to or forming part thereof. The Policy contains details of the extent of cover available to the Insured person, what is excluded from the cover and the terms & conditions on which the Policy is issued to The Insured person.

2.44 **POLICY PERIOD** means period of one policy year as mentioned in the schedule for which the Policy is issued.

2.45 **POLICY SCHEDULE** means the Policy Schedule attached to and forming part of Policy.

2.46 **POLICY YEAR** means a period of twelve months beginning from the date of commencement of the policy period and ending on the last day of such twelve-month period. For the purpose of subsequent years, policy year shall mean a period of twelve months commencing from the end of the previous policy year and lapsing on the last day of such twelve-month period, till the policy period, as mentioned in the schedule.

2.47 **SUM INSURED** is the maximum amount of coverage opted for each Insured Person and shown in the Schedule.

2.48 **THIRD PARTY ADMINISTRATORS (TPA)** means a Company registered with the Authority, and engaged by an Insurer, for a fee or by whatever name called and as may be mentioned in the health services agreement, for providing health services.

2.49 **WAITING PERIOD** means a period from the inception of this Policy during which specified diseases / treatments are not covered. On completion of the period, diseases / treatments shall be covered provided the Policy has been continuously renewed without any break.

3.0 BENEFITS COVERED UNDER THE POLICY

NOW THIS POLICY WITNESSES that subject to the terms, conditions, exclusions and definitions contained herein or endorsed or otherwise expressed here on the Company undertakes that if during the period stated in the Schedule or during the continuance of this policy by renewal any Insured Person shall contract any Illness (herein defined)or sustain any Injury (herein defined) and if such Injury shall require any such Insured Person, upon the advice of a duly qualified Medical practitioner (herein defined) or a surgeon to incur Medical Expenses/Surgery at any Hospital / Day Care Center (herein defined)in India as an Inpatient, the Company will pay to the Insured Person the amount of such expenses as good fall under different heads mentioned below, and as are Reasonably and Customarily, and Medically Necessarily incurred thereof by or on behalf of such Insured Person.

3.1 Room rent, Boarding, DMO / RMO / CMO / RMP Charges, Nursing (Including Injection / Drugs and Intra venous fluid administration expenses), not exceeding 1% of Sum Insured per day.

3.2 Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU), Intensivist charges, Monitor and Pulse Oxymeter expenses, not exceeding 2% of the sum insured per day.

3.3 Associate Medical Expenses; such as Professional fees of Surgeon, Anaesthetist, Consultant, Specialist; Anaesthesia, Blood, Oxygen, Operating Theatre Charges and Procedure Charges such as Dialysis, Chemotherapy, Radiotherapy & similar medical expenses related to the treatment.

3.4 Cost of Pharmacy and Consumables, Cost of Implants and Medical Devices and Cost of Diagnostics.

3.5 Pre-hospitalization medical charges up to 30 days period.

3.6 Post-hospitalization medical charges up to 60 days period.

NOTE: SUB-LIMIT CLAUSE

1. **Proportionate Deduction:** Proportionate Deduction is applicable on the Associate Medical Expenses, if the Insured Person opts for a higher Room than his eligible category. It shall be effected in the same proportion as the eligible rate per day bears to the actual rate per day of Room Rent. However, it is not applicable on
    1. Cost of Pharmacy and Consumables
    2. Cost of Implants and Medical Devices
    3. Cost of Diagnostics.

   Proportionate Deduction shall also not be applied in respect of Hospitals which do not follow differential billing or for those expenses in which differential billing is not adopted based on the room category, as evidenced by the Hospital's schedule of charges / tariff.

2. No payment shall be made under 3.3 other than as part of the hospitalization bill.

3. However, the bills raised by Surgeon, Anesthetist directly and not included in the hospitalization bill may be reimbursed in the following manner:
    a. The reasonable, customary and Medically Necessary Surgeon fee and Anesthetist fee would be reimbursed, limited to the maximum of 25% of Sum Insured. The payment shall be reimbursed provided the insured pays such fee(s) through cheque and the Surgeon / Anesthetist provides a numbered bill. Bills given on letter-head of the Surgeon, Anesthetist would not be entertained.
    b. Fees paid in cash will be reimbursed up to a limit of Rs. 10,000/- only, provided the Surgeon/Anesthetist provides a numbered bill.

(N.B: Company's Liability in respect of all claims admitted during the Policy Period shall not exceed the Sum Insured per person mentioned in the schedule. In case of Floater basis, the limit shall apply to the Floater Sum Insured and not to per person.)

3.7 **AYUSH:** Expenses incurred for Ayurvedic / Homeopathic / Unani Treatment are admissible up to 25% of the sum insured provided the treatment for Illness and accidental injuries, is taken in AYUSH Hospital.

3.8 Ambulances services – 1.0 % of the sum insured or actual, whichever is less, subject to maximum of Rs. 2,500/- in case patient has to be shifted from residence to hospital for admission in Emergency Ward or ICU or from one Hospital to another Hospital by fully equipped ambulance for better medical facilities.

3.9 Hospitalization expenses (excluding cost of organ) incurred on the donor during the course of organ transplant to the insured person. The Company's liability towards expenses incurred on the donor and the insured recipient shall not exceed the sum insured of the insured person receiving the organ.

3.10 SPECIFIC COVERAGES:

a) **Impairment of Persons' intellectual faculties** by usage of drugs, stimulants or depressants as prescribed by a medical practitioner is covered up to 5% of Sum Insured, maximum upto Rs. 25,000 per policy period, subject to it arising during treatment of covered illness for an admissible claim. This amount shall be part of the Sum Insured.

b) **Artificial life maintenance**, including life support machine use, where such treatment will not result in recovery or restoration of the previous state of Health under any circumstances unless in a vegetative state as certified by the treating medical practitioner, is covered up to 10% of Sum Insured and for a maximum of 15 days per policy period following admission for a covered illness. (Explanation: Expenses up to the date of confirmation by the treating doctor that the patient is in vegetative state shall be covered as per the terms and conditions of the policy contract). Such expenses shall be payable if required in conjunction to an admissible claim and shall be within the Sum insured

c) **Puberty and Menopause related Disorders:** Treatment for any symptoms, Illness, complications arising due to physiological conditions associated with Puberty, Menopause such as menopausal bleeding or flushing is covered only as Inpatient procedure after 24 months of continuous coverage. This cover will have a sub-limit of up to 25% of Sum Insured per policy period.

d) **Age Related Macular Degeneration (ARMD)** is covered after 48 months of continuous coverage only for Intravitreal Injections and anti – VEGF medication. This cover will have a sub-limit of 10% of Sum Insured, maximum upto Rs. 75,000 per policy period. This limit shall be within the Sum Insured and does not increase the overall Sum Insured.

e) **Behavioural and Neuro Developmental Disorders:** Disorders of adult personality and Disorders of speech and language including stammering, dyslexia; are covered as Inpatient procedure after 24 months of continuous coverage. This cover will have a sub-limit of 25% of Sum Insured per policy period. This limit shall be within the Sum Insured and does not increase the overall Sum Insured.

f) **Genetic diseases or disorders** are covered with a sub-limit of 25% of Sum Insured per policy period with 48 months waiting periods. This limit shall be within the Sum Insured and does not increase the overall Sum Insured.

Note: For the coverages defined in 3.11 (a) to (f), waiting period's, if any, shall be applicable afresh i.e. for both New and Existing Policyholders w.e.f. 1st October 2020 or date of inception of first policy, whichever is later. Coverage for such Illness or procedures shall only be available after completion of the said waiting periods.

g) **Treatment of mental illness, stress or psychological disorders and neurodegenerative disorders:** We shall indemnify the Hospital or the Insured the Medical Expenses (including Pre and Post Hospitalisation Expenses) related to following and they are covered after a waiting period of 48 months with a sub-limit up to 25% of Sum Insured per policy period.

The below covers are subject to the patient simultaneously exhibiting the following traits and requiring Hospitalisation as per the treating Psychiatrist's advice

1. Major Depressive Disorder- when the patient is aggressive or violent.
2. Acute psychotic conditions – aggressive / violent behavior or hallucinations, incoherent talking or agitation.
3. Schizophrenia - esp. Psychotic episodes.
4. Bipolar disorder - manic phase.

Treatment of any Injury due to Suicidality shall not be covered.

Condition

Treatment shall be undertaken at a Hospital categorized as Mental Health Establishment or at a Hospital with a specific department for Mental Illness, under a Medical Practitioner qualified as Mental Health Professional.

Exclusions

Any kind of Psychological counselling, cognitive / family / group / behavior / palliative therapy or other kinds of psychotherapy for which Hospitalisation is not necessary shall not be covered.

Note: For the coverages defined in 3.11 (g), waiting period shall be applicable for both New and Existing Policyholders w.e.f 16th August 2018 or date of inception of first policy, whichever is later. This Coverage shall only be available after completion of the said waiting period.

3.11 COVERAGE FOR MODERN TREATMENTS OR PROCEDURES: The following procedures will be covered (wherever medically indicated) either as in patient or as part of day care treatment in a hospital up to the limit specified against each procedure during the policy period.

S No	Treatment or Procedure	Limit (Per Policy Period)
3.12.1	Uterine Artery Embolization and HIFU (High intensity focused ultrasound)	Upto 20% of Sum Insured subject to Maximum Rs. 2 Lakh
3.12.2	Balloon Sinuplasty.	Upto 20% of Sum Insured subject to Maximum Rs. 2 Lakh
3.12.3	Deep Brain stimulation.	Upto 50% of Sum Insured subject to Maximum Rs. 5 Lakh
3.12.4	Oral chemotherapy.	Upto 10% of Sum Insured subject to Maximum Rs. 1 Lakh.
3.12.5	Immunotherapy- Monoclonal Antibody to be given as injection.	Upto 25% of Sum Insured subject to Maximum Rs 2 Lakh.
3.12.6	Intravitreal injections.	Upto 10% of Sum Insured subject to Maximum Rs.75,000.
3.12.7	Robotic surgeries.	Upto 50% of Sum Insured subject to Maximum Rs. 5 Lakh.
3.12.8	Stereotactic radio surgeries.	Upto 50% of Sum Insured subject to Maximum Rs. 3 Lakh.
3.12.9	Bronchial Thermoplasty.	Upto 50% of Sum Insured subject to Maximum Rs. 2.5 Lakh.

3.12.10	Vaporisation of the prostrate (Green laser treatment or holmium laser treatment).	Upto 50% of Sum Insured subject to Maximum Rs. 2.5 Lakh.
3.12.11	IONM - (Intra Operative Neuro Monitoring).	Upto 10% of Sum Insured subject to Maximum Rs. 50,000.
3.12.12	Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered.	Upto 50% of Sum Insured subject to Maximum Rs. 2.5 Lakh.

4.0 EXCLUSIONS:

The Company shall not be liable to make any payment under this policy in respect of:

STANDARD EXCLUSIONS

4.1 PRE-EXISTING DISEASES (Code- Excl01)

a. Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 48 months of continuous coverage after the date of inception of the first policy with us.

b. In case of enhancement of Sum Insured the exclusion shall apply afresh to the extent of Sum Insured increase.

c. If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations then waiting period for the same would be reduced to the extent of prior coverage.

d. Coverage under the policy after the expiry of 48 months for any pre-existing disease is subject to the same being declare

4.2 FIRST NINTY DAYS WAITING PERIOD (Code- Excl03)

a. Expenses related to the treatment of any illness within 90 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.

b. This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.

c. The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

4.3 Permanent Exclusions: Any medical expenses incurred for or arising out of:

4.4.1 INVESTIGATION & EVALUATION (Code- Excl04)

a. Expenses related to any admission primarily for diagnostics and evaluation purposes.

b. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment

However, Treatment for any symptoms, Illness, complications arising due to physiological conditions for which aetiology is unknown is not excluded. It is covered with a Sub-Limit of upto 10% of Sum Insured per policy period.

4.4.2 REST CURE, REHABILITATION AND RESPITE CARE (Code- Excl05) Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:

a. Custodial care either at home or in a nursing facility for personal care such as help with

activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.

b. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

However, Expenses related to any admission primarily for enteral feedings is not excluded, if the Oral intake is absent for a period of at-least 5 days. It will be covered for a Maximum period of 14 days in a Policy Period.

4.4.3 **OBESITY/ WEIGHT CONTROL (Code- Excl06)** Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:

a. Surgery to be conducted is upon the advice of the Doctor
b. The surgery/Procedure conducted should be supported by clinical protocols
c. The member has to be 18 years of age or older and
d. Body Mass Index (BMI);
    1. greater than or equal to 40 or
    2. greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
        i. Obesity-related cardiomyopathy
        ii. Coronary heart disease
        iii. Severe Sleep Apnea
        iv. Uncontrolled Type2 Diabetes

4.4.4 **CHANGE-OF-GENDER TREATMENTS (Code- Excl07)**

Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

4.4.5 **COSMETIC OR PLASTIC SURGERY (Code- Excl08)**

Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.

4.4.6 **HAZARDOUS OR ADVENTURE SPORTS (Code- Excl09)**

Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

However, Treatment related to Injury or Illness associated with Hazardous activities related to particular line of employment or occupation (not for recreational purpose) is not excluded.

4.4.7 **BREACH OF LAW (Code- Excl10)**

Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

4.4.8 **EXCLUDED PROVIDERS (Code-Excl11)**

Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the policyholders are not admissible. However, in case of life-threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.

4.4.9 Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. **(Code- Excl12)**

4.4.10 Treatments received in health hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons. **(Code- Excl13)**

4.4.11 Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure. **(Code- Excl14)**

4.4.12 REFRACTIVE ERROR (Code- Excl15)

Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptres.

4.4.13 UNPROVEN TREATMENTS (Code- Excl16)

Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

4.4.14 STERILITY AND INFERTILITY (Code- Excl17)

Expenses related to sterility and infertility. This includes:

a. Any type of contraception, sterilization
b. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
c. Gestational Surrogacy
d. Reversal of sterilization

4.4.15 MATERNITY EXPENSES (Code - Excl18)

a. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalization) except ectopic pregnancy;
b. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.

SPECIFIC EXCLUSIONS

4.4.16 War (whether declared or not) and war like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolutions, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainment of all kinds.

4.4.17 Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion:

a. Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or death.
b. Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.
c. Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced

toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.

4.4.18 Circumcision unless required to treat Injury or Illness.

4.4.19 Vaccination & Inoculation.

4.4.20 Cost of braces, equipment or external prosthetic devices, non-durable implants, eyeglasses, Cost of spectacles and contact lenses, hearing aids including cochlear implants, durable medical equipment.

4.4.21 All types of Dental treatments except arising out of an accident.

4.4.22 Convalescence, general debility.

4.4.23 Bodily injury or sickness due to willful or deliberate exposure to danger (except in an attempt to save human life), intentional self-inflicted injury, attempted suicide.

However, Failure to seek or follow medical advice or failure to follow treatment is not excluded. It is covered with a sub-limit of 10% of Sum Insured per policy period.

4.4.24 Naturopathy Treatment.

4.4.25 Instrument used in treatment of Sleep Apnea Syndrome (C.P.A.P.) and continuous Peritoneal Ambulatory dialysis (C.P.A.D.) and Oxygen Concentrator for Bronchial Asthmatic condition.

4.4.26 Stem cell implantation / surgery for other than those treatments mentioned in clause 3.12.12.

4.4.27 Domiciliary Hospitalization.

4.4.28 Treatment taken outside India.

4.4.29 Change of treatment from one system to another unless recommended by the consultant / hospital under whom the treatment is taken.

4.4.30 Service charges or any other charges levied by hospital, except registration/admission charges.

4.4.31 Treatment such as Rotational Field Quantum Magnetic Resonance (RFQMR), External Counter Pulsation (ECP), Enhanced External Counter Pulsation (EECP), Hyperbaric Oxygen Therapy.

5.0 GENERAL TERMS AND CLAUSES:

5.1 MULTIPLE POLICIES:

1. In case of multiple policies taken by Insured Person during a period from the Company or one or more Insurers to indemnify treatment costs, Insured Person shall have the right to require a settlement of Insured Person's claim in terms of any of his/her policies. In all such cases the Company, if chosen by Insured Person, shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of this Policy.
2. Insured having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies, even if the Sum Insured is not exhausted. Then We shall independently settle the claim subject to the terms and

conditions of this Policy.

3. If the amount to be claimed exceeds the Sum Insured under a single policy after, Insured Person shall have the right to choose Insurers from whom You wants to claim the balance amount.
4. Where an Insured has policies from more than one Insurer to cover the same risk on indemnity basis, the Insured shall only be indemnified the Hospitalisation costs in accordance with the terms and conditions of the chosen policy.

Note: The Insured Person must disclose such other insurance at the time of making a claim under this Policy.

5.2 FRAUD, MISREPRESENTATION, CONCEALMENT: The policy shall be null and void and no benefits shall be payable in the event of misrepresentation, misdescription or nondisclosure of any material fact/particulars if such claim be in any manner fraudulent or supported by any fraudulent means or device whether by the Insured Person or by any other person acting on his/her behalf.

5.3 RENEWAL CLAUSE: The Company sends renewal notice as a matter of courtesy. If the insured does not receive the renewal notice it will not amount to any deficiency of service.

The Company shall not be responsible or liable for non-renewal of the policy due to non-receipt /delayed receipt of renewal notice or due to any other reason whatsoever.

We shall be entitled to decline renewal if:

a) Any fraud, moral hazard/misrepresentation or suppression by You or any one acting on Your behalf is found either in obtaining insurance or subsequently in relation thereto, or non-cooperation of the Insured Person, or
b) We have discontinued issue of the Policy, in which event You shall however have the option for renewal under any similar Policy being issued by Us; provided however, benefits payable shall be subject to the terms contained in such other Policy, or
c) You fail to remit Premium for renewal before expiry of the Policy Period. We may accept renewal of the Policy if it is effected within thirty days (grace period) of the expiry of the Policy Period. On such acceptance of renewal, we, however shall not be liable for any claim arising out of Illness contracted or Injury sustained or Hospitalization commencing in the

interim period after expiry of the earlier Policy and prior to date of commencement of subsequent Policy

5.4 **GRIEVANCE REDRESSAL:** In the event of Insured has any grievance relating to the insurance, Insured Personmay contact any of the Grievance Cells at Regional Offices of the Company or Office of the Insurance Ombudsman under the jurisdiction of which the Policy Issuing Office falls. The contact details of the office of the Insurance Ombudsman are provided in the Annexure II.

Senior Citizens may write to seniorcitizencare.ho@newindia.co.in

5.5 **PREMIUM PAYMENT:** The premium payable under this policy shall be paid in advance. No receipt for Premium shall be valid except on the official form of the Company. The due payment of premium and the observance and fulfillment of the terms, provisions, conditions and endorsements of this policy by the Insured Person in so far as they relate to anything to be done or complied with by the Insured Person shall be condition precedent to any liability of the Company to make any payment under this policy. No waiver of any terms, provisions, conditions and endorsements of this policy shall be valid, unless made in writing and signed by an authorized official of the Company.

5.6 **PHYSICAL EXAMINATION:** Any medical practitioner authorized by the Company shall be allowed to examine the Insured Person in case of any alleged injury or Illness requiring Hospitalization when and so often as the same may reasonably be required on behalf of the Company.

5.7 The Company shall not be liable to make any payment under this policy in respect of any claim if such claim be in any manner fraudulent or supported by any fraudulent means or device whether by the Insured Person or by any other person acting on his behalf.

5.8 **DISCLAIMER OF CLAIM:** If the Company shall disclaim liability to the Insured for any claim hereunder and if the Insured shall not within 12 calendar months from the date of receipt of the notice of such disclaimer notify the Company in writing that he does not accept such disclaimer and intends to recover his claim from the Company then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

5.9 All medical / surgical treatment under this policy shall have to be taken in India and admissible claims thereof shall be payable in Indian currency.

6.0 CASHLESS SERVICE THROUGH TPAS: Claims in respect of Cashless access services will be through the agreed list of network of hospital and is subject to pre-admission authorization. The TPA shall, upon getting the related medical information from the Insured Person / networkprovider, verify that the person is eligible to claim under the policy and after satisfying itself will issue a pre-authorization letter / guarantee of payment letter to the hospital mentioning the sum guaranteed as payable also the ailment for which the person is seeking to be admittedas a patient. The TPA reserves the right to deny pre-authorization in case the insured person is unable to provide the relevant medical details as required by the TPA. The TPA will make it clear to the insured person that denial of Cashless Access is in no way construed to be denial of treatment. The insured person may obtain the treatment as per his /her treating Medical Practitioners medical advice and later on submit the full claim papers to the TPA for reimbursement.

7.0 MEDICAL EXPENSES FOLLOWING UNDER TWO POLICY PERIODS: If the claim event falls within two Policy Periods, the claims shall be paid taking into consideration the available Sum Insured of the expiring Policy only. Sum Insured of the renewed Policy will not be available for the Hospitalisation (including Pre & Post Hospitalisation Expenses), which has commenced in the expiring Policy. Claim shall be settled on per event basis.

8.0 REPUDIATION OF CLAIM: A claim, which is not covered under the Policy conditions, can be rejected. All the documents submitted to TPA shall be electronically collected by Us for settlement and denial of the claims by the appropriate authority.

With Our prior approval Communication of repudiation shall be sent to You, explicitly mentioning the grounds for repudiation, through Our TPA.

9.0 PROTECTION OF POLICY HOLDERS' INTEREST: This policy is subject to IRDA (Protection of Policyholders' Interest) Regulation, 2017.

10.0 ARBITRATION: If we admit liability for any claim but any difference or dispute arises as to the amount payable for any claim the same shall be decided by reference to Arbitration.

The Arbitrator shall be appointed in accordance with the provisions of the Arbitration and Conciliation Act, 1996.

No reference to Arbitration shall be made unless We have Admitted our liability for a claim in writing.

If a claim is declined and within 12 calendar months from such disclaimer any suit or proceeding is not filed then the claim shall for all purposes be deemed to have been abandoned and shall not thereafter be recoverable hereunder.

11.0 The expenses that are not covered in this policy are placed under List-I of Annexure-I. The list of expenses that are to be subsumed into room charges, or procedure charges or costs of treatment are placed under List-II, List-III and List-IV of Annexure-I respectively.

ANNEXURE I:

List I – Items for which coverage is not available in the policy

S No	Item
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS / BRACES
5	BUDS
6	COLD PACK / HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	TELEVISION CHARGES
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36	SPACER
37	SPIROMETRE
38	NEBULIZER KIT
39	STEAM INHALER
40	ARMSLING
41	THERMOMETER
42	CERVICAL COLLAR
43	SPLINT

44	DIABETIC FOOT WEAR
45	KNEE BRACES (LONG / SHORT / HINGED)
46	KNEE IMMOBILIZER / SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELT
48	NIMBUS BED OR WATER OR AIR BED CHARGES
49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT
51	ABDOMINAL BINDER

52	PRIVATE NURSES CHARGES - SPECIAL NURSING CHARGES
53	SUGAR FREE TABLETS
54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	ANY KIT WITH NO DETAILS MENTIONED (DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC)
59	KIDNEY TRAY
60	MASK
61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLY COVER
66	UROMETER, URINE JUG
67	AMBULANCE
68	VASOFIX SAFETY

List II – Items that are to be subsumed into Room Charges

S No	Item
1	BABY CHARGES (UNLESS SPECIFIED / INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB
7	EAU-DE-COLOGNE / ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN
15	FACE MASK
16	FLEXI MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKET / WARMER BLANKET
27	ADMISSION KIT
28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES

35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36	PATIENT IDENTIFICATION BAND / NAME TAG
37	PULSEOXYMETER CHARGES

List III – Items that are to be subsumed into Procedure Charges

S No	Item
1	HAIR REMOVAL CREAM
2	DISPOSABLES RAZORS CHARGES (for site preparations)
3	EYE PAD
4	EYE SHEILD
5	CAMERA COVER
6	DVD, CD CHARGES
7	GAUSE SOFT
8	GAUZE
9	WARD AND THEATRE BOOKING CHARGES
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11	MICROSCOPE COVER
12	SURGICAL BLADES, HARMONICSCALPEL, SHAVER
13	SURGICAL DRILL
14	EYE KIT
15	EYE DRAPE
16	X-RAY FILM
17	BOYLES APPARATUS CHARGES
18	COTTON
19	COTTON BANDAGE
20	SURGICAL TAPE
21	APRON
22	TORNIQUET
23	ORTHOBUNDLE, GYNAEC BUNDLE

List IV – Items that are to be subsumed into costs of treatment

S No	Item
1	ADMISSION / REGISTRATION CHARGES
2	HOSPITALISATION FOR EVALUATION / DIAGNOSTIC PURPOSE
3	URINE CONTAINER
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES
5	BIPAP MACHINE
6	CPAP / CAPD EQUIPMENTS
7	INFUSION PUMP - COST
8	HYDROGEN PEROXIDE / SPIRIT / DISINFECTANTS ETC
9	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES
10	HIV KIT
11	ANTISEPTIC MOUTHWASH
12	LOZENGES
13	MOUTH PAINT
14	VACCINATION CHARGES
15	ALCOHOL SWABES
16	SCRUB SOLUTION / STERILLIUM
17	GLUCOMETER & STRIPS
18	URINE BAG

THE NEW INDIA ASSURANCE CO. LTD.

REGISTERED & HEAD OFFICE: 87, MAHATMA GANDHI ROAD, MUMBAI - 400 001.

1. PREAMBLE

This is Your **"YUVA BHARAT HEALTH POLICY"**, which has been issued by Us, relying on the information disclosed by You in Your Proposal for this Policy or its preceding Policy/Policies of which this is a renewal.

The terms and conditions set out in this Policy and its Schedule will be the basis for any claim and/or benefit under this Policy.

Please read this Policy carefully and point out discrepancy, if any, in the Schedule. Otherwise, it will be presumed that the Policy and the Schedule correctly represent the cover agreed upon.

If during the Period of Insurance, You or any Insured Person incurs Hospitalisation Expenses which are Reasonable and Customary, and Medically Necessary for treatment of any Illness or Injury, we will reimburse such expense through the Third-Party Administrator incurred by You in the manner stated herein.

The Coverages are as under.

Hospitalisation Expenses	Specific Coverages
Medical Expenses For Organ Transplant	Coverage For Modern Treatments Or Procedures
Hospital Cash	Cost Of Health Check-Up
Road Ambulance Charges	Medical Second Opinion
Treatment For Congenital Diseases	Air Ambulance Charges
Coverage For Cataract	Treatments Under Ayurvedic / Yoga and Naturopathy /Homeopathic / Siddha/ Unani Systems
Coverage For Hazardous Sports	New Born Baby Coverage
Shared Accommodation Benefit	

Maternity Coverage	Infertility Treatment
Well baby Cover	Birth Right Benefit

2. DEFINITIONS

STANDARD DEFINITIONS

2.1 **ACCIDENT** means a sudden, unforeseen and involuntary event caused by external, visible and violent means.

2.2 **ANY ONE ILLNESS** means continuous Period of Illness and it includes relapse within 45 days from the date of last consultation with the Hospital where treatment may have been taken.

2.3 **AYUSH HOSPITAL** is a Healthcare facility wherein medical / surgical / para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following:

a. Central or State Government AYUSH Hospital or

b. Teaching hospital attached to AYUSH College recognized by the Central Government / Central Council of Indian Medicine / Central Council for Homeopathy; or

c. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion:

i. Having at least 5 in-patient beds;

ii. Having qualified AYUSH Medical Practitioner in charge round the clock;

iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;

iv. Maintaining daily records of the patients and making them accessible to the insurance Company's authorized representatives.

2.4 **AYUSH DAY CARE CENTRE** means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner(s) on day care basis without in-patient services and must comply with all the following criterion:

i. Having qualified registered AYUSH Medical Practitioner(s) in charge;

ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;

iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.

2.5 **BANK RATE** means Bank rate fixed by the Reserve Bank of India (RBI) which is prevalent as on 1st day of the financial year in which the claim has fallen due.

2.6 **CASHLESS FACILITY** means a facility extended by Us to You where the payments, of the costs of treatment undergone by You in accordance with the policy terms and conditions, are directly made to the Network provider by Us to the extent of pre-authorization approved.

2.7 **CONDITION PRECEDENT** means a Policy term or condition upon which Our liability under the Policy is conditional upon.

2.8 **CONGENITAL ANOMALY** refers to a condition(s) which is present since birth, and which is abnormal with reference to form, structure or position.

i. CONGENITAL INTERNAL ANOMALY means a Congenital Anomaly which is not in the visible and accessible parts of the body.

ii. CONGENITAL EXTERNAL ANOMALY means a Congenital Anomaly which is in the visible and accessible parts of the body.

2.9 **CRITICAL ILLNESSES** mean the following Illnesses:

2.9.1 **CANCER OF SPECIFIED SEVERITY** means

9.1.I. A malignant tumour characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer includes leukaemia, lymphoma and sarcoma.

9.1.II. The following are excluded -

9.1.II.i. All tumors which are histologically described as carcinoma in situ, benign, pre- malignant, borderline malignant, low malignant potential, neoplasm of unknown behavior, or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN-2 and CIN-3.

9.1.II.ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond.

9.1.II.iii. Malignant melanoma that has not caused invasion beyond the epidermis.

9.1.II.iv. All tumors of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0

9.1.II.v. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below;

9.1.II.vi. Chronic lymphocytic leukaemia less than RAI stage 3

9.1.II.vii. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification,

9.1.II.viii. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs;

9.1.II.ix. All tumors in the presence of HIV infection.

2.9.2 **MYOCARDIAL INFARCTION (FIRST HEART ATTACK OF SPECIFIED SEVERITY)**

9.2.I. The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria:

9.2.I.i. a history of typical clinical symptoms consistent with the diagnosis of Acute Myocardial Infarction (for e.g. typical chest pain)

9.2.I.ii. New characteristic electrocardiogram changes

9.2.I.iii. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

9.2.II. The following are excluded:

9.2.II.i. Other acute Coronary Syndromes

9.2.II.ii. Any type of angina pectoris.

9.2.II.iii. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure.

2.9.3 **OPEN CHEST CABG**

9.3.I. The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.

9.3.II. The following are excluded:

9.3.II.i. Angioplasty and/or any other intra-arterial procedures

2.9.4 **OPEN HEART REPLACEMENT OR REPAIR OF HEART VALVES**

9.4.I. The actual undergoing of open-heart valve Surgery is to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease- affected cardiac valve(s). The diagnosis of the valve abnormality must be supported by an echocardiography and the realization of Surgery has to be confirmed by a specialist Medical Practitioner. Catheter based techniques including but not limited to, balloon valvotomy/valvuloplasty are excluded.

2.9.5 **COMA OF SPECIFIED SEVERITY**

9.5.I. A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:

9.5.I.i. No response to external stimuli continuously for at least 96 hours;

9.5.I.ii. Life support measures are necessary to sustain life; and

9.5.I.iii. Permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

9.5.II. The condition has to be confirmed by a specialist Medical Practitioner. Coma resulting directly from alcohol or drug abuse is excluded.

2.9.6 **KIDNEY FAILURE REQUIRING REGULAR DIALYSIS**

9.6.I. End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (haemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist Medical Practitioner.

2.9.7 **STROKE RESULTING IN PERMANENT SYMPTOMS**

9.7.I. Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be

confirmed by a specialist Medical Practitioner and evidenced by typical clinical symptoms as well as typical findings in CT scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced

9.7.II. The following are excluded:

9.7.II.i. Transient ischemic attacks (TIA)

9.7.II.ii. Traumatic injury of the brain

9.7.II.iii. Vascular disease affecting only the eye or optic nerve or vestibular functions.

2.9.8 **MAJOR ORGAN /BONE MARROW TRANSPLANT**

9.8.I. The actual undergoing of a transplant of:

9.8.I.i. One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or

9.8.I.ii. Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist Medical Practitioner.

9.8.II. The following are excluded:

9.8.II.i. Other stem-cell transplants

9.8.II.ii. Where only islets of Langerhans are transplanted

2.9.9 **PERMANENT PARALYSIS OF LIMBS**

9.9.I. Total and irreversible loss of use of two or more limbs as a result of injury or disease of the brain or spinal cord. A **specialist** Medical Practitioner must be of the opinion that the paralysis will be permanent with no hope of recovery and must be present for more than 3 months.

2.9.10 **MOTOR NEURONE DISEASE WITH PERMANENT SYMPTOMS**

9.10.I. Motor neurone disease diagnosed by a specialist Medical Practitioner as spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be progressive degeneration of cortico spinal tracts and anterior horn cells or bulbar efferent neurons. There must be current significant and permanent functional neurological impairment with objective evidence of motor dysfunction that has persisted for a continuous period of at least 3 months.

2.9.11 **MULTIPLE SCLEROSIS WITH PERSISTING SYMPTOMS**

9.11.I. The definite occurrence of multiple sclerosis. The diagnosis must be supported by all of the following:

9.11.I.i. Investigations including typical MRI and CSF findings, which unequivocally confirm the diagnosis to be multiple sclerosis and

9.11.I.ii. There must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months

9.11.II. Other causes of neurological damage such as SLE and HIV are excluded.

2.9.12 **THIRD DEGREE BURNS**

There must be third-degree burns with scarring that cover at least 20% of the body's surface area. The diagnosis must confirm the total area involved using standardized, clinically accepted, body surface area charts covering 20% of the body surface area.

2.9.13 **MAJOR HEAD TRAUMA**

9.13.I. Accidental head injury resulting in permanent Neurological deficit to be assessed no sooner than 3 months from the date of the accident. This diagnosis must be supported by unequivocal findings on Magnetic Resonance Imaging, Computerized Tomography, or other reliable imaging techniques. The accident must be caused solely and directly by accidental, violent, external and visible means and independently of all other causes.

9.13.II. The Accidental Head injury must result in an inability to perform at least three (3) of the following Activities of Daily Living either with or without the use of mechanical equipment, special devices or other aids and adaptations in use for disabled persons. For the purpose of this benefit, the word "permanent" shall mean beyond the scope of recovery with current medical knowledge and technology.

9.13.III. The Activities of Daily Living are:

a. **Washing:** the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
b. **Dressing:** the ability to put on, take off, secure and unfasten all garments and, as appropriate, any braces, artificial limbs or other surgical appliances;
c. **Transferring:** the ability to move from a bed to an upright chair or wheelchair and vice versa;
d. **Mobility:** the ability to move indoors from room to room on level surfaces;
e. **Toileting:** the ability to use the lavatory or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
f. **Feeding:** the ability to feed oneself once food has been prepared and made available.
   i. The following are excluded:
      - Spinal cord injury

2.9.14 **END STAGE LUNG FAILURE**

End stage lung disease, causing chronic respiratory failure, as confirmed and evidenced by all of the following:

a. FEV1 test results consistently less than 1 litre measured on 3 occasions 3 months apart; and
b. Requiring continuous permanent supplementary oxygen therapy for hypoxemia; and
c. Arterial blood gas analysis with partial oxygen pressure of 55mmHg or less (PaO2 < 55mmHg); and
d. Dyspnea at rest.

2.9.15 **END STAGE LIVER FAILURE**

9.15.I. Permanent and irreversible failure of liver function that has resulted in all three of the following:

a. Permanent jaundice; and
b. Ascites; and
c. Hepatic encephalopathy.

9.15.II. Liver failure secondary to drug or alcohol abuse is **excluded**.

2.10 **CO-PAYMENT** is a cost-sharing requirement under a health insurance policy that provides that the Insured Person will bear a specified percentage of the admissible claim amount. A co- payment does not reduce the Sum Insured.

2.11 **DAY CARE CENTRE** means any institution established for day care treatment of Illness or Injury, or a medical set-up within a hospital and which has been registered with the local authorities, wherever applicable, and is under the supervision of a registered and qualified Medical Practitioner AND must comply with all minimum criteria as under:

- has qualified nursing staff under its employment
- has qualified Medical Practitioner(s) in charge
- has a fully equipped operation theatre of its own where Surgery is carried out
- maintains daily records of patients and will make these accessible to the Insurance Company's authorized personnel.

2.12 **DAY CARE TREATMENT** refers to medical treatment or Surgery which are:

- undertaken under general or local anesthesia in a Hospital/ Day Care Centre in less than 24 hours because of technological advancement, and
- which would have otherwise required a Hospitalisation of more than 24 hours.

Treatment normally taken on an out-patient basis is not included in the scope of this definition.

2.13 **DENTAL TREATMENT** is treatment carried out by a dental practitioner including examinations, fillings (where appropriate), crowns, extractions and Surgery.

2.14 **DISCLOSURE TO INFORMATION NORM:** The policy shall be void and all premium paid thereon shall be forfeited to Us in the event of misrepresentation, mis-description or non-disclosure of any material fact.

2.15 **DOMICILIARY HOSPITALIZATION** means medical treatment for an illness/disease/injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances:

i. the condition of the patient is such that he/she is not in a condition to be removed to a hospital, or
ii. the patient takes treatment at home on account of non-availability of room in a hospital

2.16 **EMERGENCY CARE** means management for an Illness or Injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a medical practitioner to prevent death or serious long-term impairment of the Insured Person's health.

2.17 **HOSPITAL** means any institution established for Inpatient Care and Day Care Treatment of Illness or Injury and which has been registered as a Hospital with the local authorities under the Clinical Establishment (Registration and Regulation) Act, 2010 or under the enactments specified under the schedule of Section 56(1) of the said act OR complies with all minimum criteria as under:

- Has qualified nursing staff under its employment round the clock;
- Has at least 10 Inpatient beds in towns having a population of less than 10,00,000 and at least 15 In-patient beds in all other places;
- Has qualified Medical Practitioner(s) in charge round the clock;
- Has a fully equipped operation theatre of its own where Surgery is carried out;
- Maintains daily records of patients and makes these accessible to the insurance company's authorized personnel.

2.18 **HOSPITALISATION** means admission as an Inpatient in a Hospital for a minimum period of 24 consecutive hours except for the procedures/ treatments mentioned in Annexure I, where such admission could be for a period of less than 24 consecutive hours.

2.19 **ILLNESS** means a sickness or a disease or pathological condition leading to the impairment of normal physiological function which manifests itself during the Policy Period and requires medical treatment.

i. **Acute Condition** means a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ illness/ injury which leads to full recovery.

ii. **Chronic Condition** means a disease, illness, or injury that has one or more of the following characteristics

a. it needs ongoing or long-term monitoring through consultations, examinations, check- ups, and / or tests

b. it needs ongoing or long-term control or relief of symptoms

c. it requires rehabilitation for the patient or for the patient to be special trained to cope with it

d. it continues indefinitely

e. it recurs or is likely to recur

2.20 **INJURY** means accidental physical bodily harm excluding Illness or disease solely and directly caused by external, violent and visible and evident means which is verified and certified by a Medical Practitioner.

2.21 **INPATIENT CARE** means treatment for which the Insured Person has to stay in a hospital for more than 24 hours for a covered event.

2.22 **INTENSIVE CARE UNIT (ICU)** means an identified section, ward or wing of a Hospital which is under the constant supervision of a dedicated Medical Practitioner and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.

2.23 **ICU (INTENSIVE CARE UNIT) CHARGES** means the amount charged by a Hospital towards ICU expenses on a per day basis which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.

2.24 **MEDICAL ADVICE** means any consultation or advice from a Medical Practitioner including the issue of any prescription or follow up prescription.

2.25 **MEDICAL EXPENSES** means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or Injury on the advice of a Medical Practitioner, as long as these are no more than would have been payable, if You had not been Insured and no more than other Hospitals or doctors in the same locality would have charged for the same medical treatment.

2.26 **MEDICALLY NECESSARY TREATMENT** means any treatment, tests, medication, or stay in Hospital or part of a stay in Hospital which

- Is required for the medical management of the Illness or Injury suffered by You;
- Must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
- Must have been prescribed by a Medical Practitioner,
- Must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

2.27 **MEDICAL PRACTITIONER** means a person who holds a valid registration from the Medical Council of any state or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of the license.

The term Medical Practitioner shall not include any Insured Person or any member of his family.

2.28 **MATERNITY EXPENSES shall mean:**

a. Medical Treatment Expenses traceable to child birth (including complicated deliveries and caesarean sections incurred during Hospitalisation),

b. Expenses towards lawful medical termination of pregnancy during the Policy Period.

2.29 **MEDICAL PRACTITIONER** means a person who holds a valid registration from the Medical Council of any state or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within the scope and jurisdiction of his license.

The term Medical Practitioner shall not include any Insured Person or any member of his family.

2.30 **MIGRATION** means a facility provided to policyholders (including all members under family cover and group Health insurance policy), to transfer the credit gained for pre-existing conditions and specific waiting period, from one health insurance policy to another with the same insurer.

2.31 **NETWORK PROVIDER** means hospitals or health care providers enlisted by an insurer, TPA or jointly by an Insurer and TPA to provide medical services to an insured by a cashless facility. The list is available with the insurer/TPA and subject to amendment from time to time.

2.32 **NON-NETWORK PROVIDER** means any Hospital, Day Care Centre or other provider that is not part of the Network.

2.33 **NEW BORN BABY** means baby born during the Policy Period and is aged up to 90 days.

2.34 **NOTIFICATION OF CLAIM** means the process of intimating a claim to Us or TPA through any of the recognized modes of communication.

2.35 **PRE-EXISTING CONDITION/DISEASE** means any condition, ailment, Injury or Illness

a. That is/are diagnosed by a physician not more than 24 months prior to the date of commencement of policy issued by the insurer or

b. For which medical advice or treatment was recommended by, or received from, a physician not more than 24 months prior to the date of commencement of policy

2.36 **PRE-HOSPITALISATION MEDICAL EXPENSES** means Medical Expenses incurred, for Any One Illness, immediately before the Insured Person is Hospitalised, provided that:

i. Such Medical Expenses are incurred for the same condition for which the Insured Person’s Hospitalisation was required, and

ii. The Inpatient Hospitalisation claim for such Hospitalisation is admissible by Us.

iii. Such Medical Expenses are incurred not earlier than sixty days before the Date of Hospitalisation.

2.37 **POST-HOSPITALISATION MEDICAL EXPENSES** means Medical Expenses incurred, for Any One Illness, immediately after the Insured Person is discharged from the Hospital, provided that:

i. Such Medical Expenses are incurred for the same condition for which the Insured Person’s Hospitalisation was required, and

ii. The In-patient Hospitalisation claim for such Hospitalisation is admissible by Us.

iii. Such Medical Expenses are incurred not later than ninety days after the date of discharge from the Hospital.

2.38 **PORTABILITY** means the facility provided to the health insurance policyholder (including all members under family cover), to transfer the credits gained for pre-existing diseases and specific waiting periods, from one insurer to another insurer.

2.39 **QUALIFIED NURSE** means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.

2.40 **REASONABLE AND CUSTOMARY CHARGES** mean the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the Illness / Injury involved.

2.41 **RENEWAL** means the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of gaining credit for pre-existing diseases, time-bound exclusions and for all waiting periods.

2.42 **ROOM RENT** means the amount charged by a hospital towards Room and Boarding expenses and shall include the associated medical expenses.

2.43 **SURGERY OR SURGICAL PROCEDURE** means manual or operative procedure required for treatment of an Illness or Injury, correction of deformities and defects, diagnosis and cure of diseases, relief of suffering or prolongation of life, performed in a hospital or Day Care Centre by a Medical Practitioner.

2.44 **UNPROVEN / EXPERIMENTAL TREATMENT** is treatment, including drug Experimental therapy, which is not based on established medical practice in India, is treatment experimental or unproven.

SPECIFIC DEFINITIONS

2.45 **AGE** means age of the Insured person on last birthday as on date of commencement of the Policy.

2.46 **ASSOCIATE MEDICAL EXPENSES** means medical expenses such as Professional fees of Surgeon, Anaesthetist, Consultant, Specialist; Operating Theatre Charges and Procedure Charges such as Dialysis, Chemotherapy, Radiotherapy and similar medical expenses related to the treatment.

2.47 **AYUSHMAN BHARAT HEALTH ACCOUNT (ABHA)** number is a hassle-free method of accessing and sharing health records digitally. It enables interaction with participating healthcare providers, and allows to receive digital lab reports, prescription and diagnosis seamlessly from a verified healthcare professionals and health service providers.

2.48 **AYUSH TREATMENT** refers to Hospitalisation treatments given under Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy systems.

2.49 **BIRTH RIGHT BENEFIT**

- **Autism spectrum disorder (ASD)** means a range of complex neurodevelopment disorders, characterized by social impairments, communication difficulties, and restricted, repetitive, and stereotyped pattern of behavior.
- **Cerebral Palsy** means a group of non-progressive neurological condition affecting body movements and muscle coordination, caused by damage to one or more specific areas of the brain, usually occurring before, during or shortly after birth.
- **Down's syndrome** means a genetic disorder which is typically associated with a delay in cognitive ability (mental retardation or MR) and physical growth and a particular set of facial characteristics.

2.50 **BREAK IN POLICY** means the period of gap that occurs at the end of the existing policy term, when the premium due for renewal on a given policy is not paid on or before the premium renewal date or within 30 days thereof.

2.51 **CANCELLATION** defines the terms on which the Policy contract can be terminated either by Us or You by giving sufficient notice to other which is not less than a period of fifteen/seven days respectively as applicable.

2.52 **CLAIM FREE YEAR** means coverage under the **YUVA BHARAT HEALTH POLICY** for a period of one year during which no claim is paid or payable under the terms and conditions of the Policy in respect of Insured Person.

2.53 **CONTINUOUS COVERAGE** means uninterrupted coverage of the Insured Person with Us, from the time the coverage first incepted under this Policy.

A break in insurance for a period not exceeding thirty days shall not be reckoned as an interruption in coverage for the purpose of this Clause. In case of change in Sum Insured during such uninterrupted coverage, the lowest Sum Insured would be reckoned for determining Continuous Coverage.

2.54 **MENTAL HEALTH ESTABLISHMENT** means any health establishment, including Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy establishment, by whatever name called, either wholly or partly, meant for the care of persons with mental illness, established, owned, controlled or maintained by the appropriate Government, local authority, trust, whether private or public, corporation, co-operative society, organisation or any other entity or person, where persons with mental illness are admitted and reside at, or kept in, for care, treatment, convalescence and rehabilitation, either temporarily or otherwise; and includes any general hospital or general nursing home established or maintained by the appropriate Government, local authority, trust, whether private or public, corporation, co-operative society, organisation or any other entity or person; but does not include a family residential place where a person with mental illness resides with his relatives or friends;

2.55 **MENTAL HEALTH PROFESSIONAL means**

i. **A Psychiatrist:** means a medical practitioner possessing a post-graduate degree or diploma in psychiatry awarded by an university recognised by the University Grants Commission established under the University Grants Commission Act, 1956, or awarded or recognised by the National Board of Examinations and included in the First Schedule to the Indian Medical Council Act, 1956, or recognised by the Medical Council of India, constituted under the Indian Medical Council Act, 1956, and includes, in relation to any State, any medical officer who having regard to his knowledge and experience in psychiatry, has been declared by the Government of that State to be a psychiatrist for the purposes of this Policy

ii. a professional registered with the concerned State Authority; (or)

iii. a professional having a post-graduate degree (Ayurveda) in Mano Vigyan Avum Manas Roga or a post-graduate degree (Homoeopathy) in Psychiatry or a post-graduate degree (Unani) in Moalijat (Nafasiyatt) or a post-graduate degree (Siddha) in Sirappu Maruthuvam.

2.56 **INFERTILITY** is defined by the failure to achieve a clinical pregnancy after twelve months or more of regular unprotected sexual intercourse.

2.57 **INSURED PERSON** means You and each of the members who are covered under this Policy as shown in the Schedule.

2.58 **LEGAL GUARDIAN OR CUSTODIAN** is a person who has taken the responsibility of taking care of or protecting the children of deceased parents. This definition is to be used for the sole purpose of taking a Health Insurance Policy. This person shall not be eligible for claiming tax rebate under section 80D of the IT act.

2.59 **PREFERRED PROVIDER NETWORK (PPN)** means network providers in specific cities which have agreed to a cashless packaged pricing for specified planned procedures for the policyholders of the Company. The list of planned procedures is available with the Company/TPA and subject to amendment from time to time. Reimbursement of expenses incurred in PPN for the procedures (as listed under PPN package) shall be subject to the rates applicable to PPN package pricing.

2.60 **POLICY** means these Policy wordings, the Policy Schedule and any applicable endorsements or extensions attaching to or forming part thereof. The Policy contains details of the coverages, exclusions and terms and conditions on which the Policy is issued to The Insured Person.

2.61 **POLICY PERIOD** means period of one policy year as mentioned in the schedule for which the Policy is issued

2.62 **POLICY SCHEDULE** means the Policy Schedule attached to and forming part of Policy.

2.63 **POLICY YEAR** means a period of twelve months beginning from the date of commencement of the policy period and ending on the last day of such twelve-month period. For the purpose of subsequent years, policy year shall mean a period of twelve months commencing from the end of the previous policy year and lapsing on the last day of such twelve-month period, till the policy period, as mentioned in the schedule.

2.64 **POLICY TERM** means the tenure of the policy, which can be 1 Year or 2 Years or 3 Years

2.65 **SUB-LIMIT** means a cost sharing requirement under this policy in which We would not be liable to pay any amount in excess of the pre-defined limit.

2.66 **SUM INSURED** means the amount specified in the Policy Schedule, which represents Our maximum, total and cumulative liability for in respect of the Insured Person for any and all claims incurred during the policy year.

Note: Sum Insured as shown in the schedule excluding Cumulative Bonus.

2.67 **TPA (THIRD PARTY ADMINISTRATORS)** means a Company registered with the Authority, and engaged by an Insurer, for a fee or by whatever name called and as may be mentioned in the health services agreement, for providing health services.

2.68 **WAITING PERIOD** means a period from the inception of this Policy during which specified diseases/treatments are not covered. On completion of the period, diseases/treatments shall be covered provided the Policy has been continuously renewed without any break.

2.69 **WARD** who are under the care or protection of the Legal Guardian or Custodian. The definition of Children shall be applicable for Ward.

2.70 **WE/OUR/US/COMPANY** means **The New India Assurance Co. Ltd.**

2.71 **YOU/YOUR** means the person who has taken this Policy and is shown as Insured Person or the first Insured Person (if more than one) in the Schedule.

3. HOW MUCH WE WILL REIMBURSE

3.1 Our liability for all claims admitted during the Period of Insurance will be only up to Sum Insured as mentioned in the Schedule. In respect of those Insured Persons with Cumulative Bonus, our liability for claims admitted under this Policy shall not exceed the aggregate of the Sum Insured and the Cumulative Bonus. Subject to this, we will reimburse the following Reasonable and Customary, and Medically Necessary Expenses admissible as per the terms and conditions of the Policy:

3.1 (a)	Room Rent including Boarding, DMO / RMO / CMO / RMP Charges, Nursing (Including Injection / Drugs and Intra venous fluid administration expenses) as provided by the hospital	
	Sum insured of Rs. 5,00,000 /10,00,000/15,00,000	
	Sum insured of Rs. 25,00,000	
3.1 (b)	Intensive Care Unit (ICU) / Intensive Cardiac Care Unit (ICCU), Intensivist charges, Monitor and Pulse Oxymeter expenses.	
3.1 (c)	Associate Medical Expenses; such as Professional fees of Surgeon, Anaesthetist, Consultant, Specialist; Operating Theatre Charges and Procedure Charges such as Dialysis, Chemotherapy, Radiotherapy and similar medical expenses related to the treatment.	
3.1 (d)	Cost of Pharmacy and Consumables including Anaesthesia, Blood, Oxygen, Cost of Implants and Medical Devices and Cost of Diagnostics.	
3.1 (e)	Pre-Hospitalization Medical expenses up to 60 days prior to the date of admission to the hospital	
3.1 (f)	Post-Hospitalization Medical expenses up to 90 days from the date of discharge from the hospital.	

Note:

Dental Treatment (Inpatient): We will cover for medical expenses incurred towards dental treatment done under anaesthesia necessitated due to an accident/injury/illness requiring Hospitalization as Inpatient treatment.

3.2 **PROPORTIONATE DEDUCTION**

Proportionate Deduction is applicable on the Associate Medical Expenses, if the Insured Person opts for a higher Room than his eligible category. It shall be effected in the same proportion as the eligible rate per day bears to the actual rate per day of Room Rent. However, it is not applicable on

1. Cost of Pharmacy and Consumables
2. Cost of Implants and Medical Devices
3. Cost of Diagnostics

Proportionate Deduction shall also not be applied in respect of Hospitals which do not follow differential billing or for those expenses in which differential billing is not adopted based on the room category, as evidenced by the Hospital's schedule of charges / tariff.

3.3 **MEDICAL EXPENSES INCURRED UNDER TWO POLICY PERIODS:**

If the claim event falls within two policy periods, the claims shall be paid taking into consideration the available Sum Insured under expiring Policy only. Sum Insured of the Renewed Policy will not be considered for the claim event which has commenced in the expiring Policy.

3.4 **MEDICAL EXPENSES FOR ORGAN TRANSPLANT:**

If treatment involves Organ Transplant to Insured Person, then We will also pay Hospitalisation Expenses (excluding cost of organ and Pre and Post Hospitalisation Expenses) incurred on the donor, provided Our liability towards expenses incurred on the donor and the Insured recipient shall not exceed the available Sum Insured.

3.5 **HOSPITAL CASH**

We will pay Hospital Cash as per the limits mentioned below for each day of Hospitalisation admissible under the Policy. The payment under this Clause shall be for maximum five days for Any One Illness.

The payment under this Clause is applicable only where the period of Hospitalisation exceeds twenty-four hours. Payment under this Clause will reduce the Sum Insured.

Hospital cash will be payable for completion of every 24 hours and not part thereof.

Sum Insured Bands in Rs.	Hospital Cash Benefit
5 lakhs, 10 lakhs & 15 lakhs	Rs. 500 per day
25 lakhs	Rs. 750 per day

3.6 **ROAD AMBULANCE CHARGES**

We will pay You the charges incurred towards Ambulance Services Reasonably incurred for shifting any Insured Person to Hospital for admission, or from one Hospital to another Hospital as per the limits mentioned below for Any One Illness.

Sum Insured Bands in Rs.	Ambulance charges payable
5 lakhs, 10 lakhs & 15 lakhs	Up to a maximum of Rs. 5,000
25 lakhs	Up to a maximum of Rs. 7,500

However, if an Insured Person, at the time of discharge from the Hospital, has to be shifted to their place of residence in an Ambulance, such expenses will also be reimbursed additionally as per the above limits, provided the requirement of an Ambulance is certified by the Medical Practitioner.

3.7 **SHARED ACCOMMODATION AS CASH BENEFIT:**

If you opt for a shared room (for which hospitalization claim is paid), we will pay an additional amount for each day's hospitalization. One day is considered as 24 continuous hours of hospitalization.

Sum Insured Bands in Rs.	Shared Accommodation Cash Benefit
5 lakhs, 10 lakhs & 15 lakhs	Rs. 750 per day
25 lakhs	Rs. 1,000 per day

3.8 **TREATMENT FOR CONGENITAL DISEASES**

Congenital Internal Disease or Defects or anomalies, except those related to Genetic disorders, shall be covered up to Sum Insured, after **twelve months** of Continuous Coverage, if it is unknown to You or to the Insured Person at the commencement of such Continuous Coverage.

Congenital External Disease or Defects or anomalies shall be covered after **twenty-four** months of Continuous Coverage, but such cover for Congenital External Disease or Defects or Anomalies shall be limited to 10% of the average Sum Insured in preceding **twenty-four** months.

3.9 **COVERAGE FOR CATARACT**

Our liability for payment of any claim within the Period of Insurance, relating to Cataract for each eye / per insured shall not exceed the limits mentioned below.

Sum Insured Bands in Rs.	Charges payable
5 lakhs, 10 lakhs & 15 lakhs	Up to a maximum of Rs. 50,000
25 lakhs	Up to a maximum of Rs. 75,000

3.10 **COVERAGE FOR HAZARDOUS SPORTS**

We shall be liable to pay expenses incurred towards treatment of any Injury or Illness arising out of the following hazardous sports:

Bobsledding; Bungee Jumping; Canopying; Hang Gliding; Heli-skiing; Horseback Riding; Jet, Snow, and Water Skiing; Kayaking; Martial Arts; Motorcycling; Mountain Biking; Mountain Climbing (under 14,000 feet); Paragliding; Parasailing; Safari; Scuba Diving, Skydiving; Snowboarding; Snowmobiling; Spelunking; Surfing; Trekking; White water Rafting; Wind Surfing; Zip Lining, Equestrian; Fencing; Rugby.

We shall reimburse the expenses as per the following limits:

Sum Insured	Amount payable per policy period
5 lakhs, 10 lakhs & 15 lakhs	10% of Sum insured subject to a maximum of Rs. 1,00,000
25 lakhs	Up to a maximum of Rs. 1,50,000

However, if Injury or Illness is related to a particular line of employment or occupation (not for recreational purpose), it will be covered up to Sum Insured.

Payment under this Clause is admissible only if the expenses are incurred in a Hospital as In-Patient in India.

3.11 **SPECIFIC COVERAGES:**

a) **Artificial life maintenance,** including life support machine use, where such treatment will not result in recovery or restoration of normal state of Health under any circumstances. We cover the expenses up to 25% of the Sum Insured and for a maximum of 15 days per policy period for covered illness. This sub limit is applicable only for person who is declared to be in a vegetative state as certified by the treating medical practitioner.

b) **Puberty and Menopause related Disorders:** Treatment for any symptoms, Illness, complications arising due to physiological conditions associated with Puberty, Menopause such as menopausal bleeding or flushing is covered only as Inpatient procedure after 12 months of continuous coverage. This cover will have a sub-limit of up to 25% of Sum Insured per policy period.

c) **Age Related Macular Degeneration (ARMD)** is covered after 24 months of continuous coverage only for Intravitreal Injections and anti - VEGF medication. This cover will have a sub-limit of up to a maximum of 20% of sum insured per policy period.

d) **Genetic diseases or disorders** are covered with a sub-limit of 25% of Sum Insured per policy period with 24 months waiting periods.

e) **Treatment of Mental Illness:** The Company shall indemnify the Medical Expenses incurred towards treatment of Mental Illness subject to the condition that Treatment shall be undertaken at a Hospital categorized as Mental Health Establishment or at a Hospital with a specific department for Mental Illness, under a Medical Practitioner qualified as Mental Health Professional.

The following Mental Illnesses are covered after completion of 24 months of Continuous Coverage with a sub-limit up to 25% of Sum Insured per policy period.

ICD Code	ICD Code Description
F01-F09	Mental disorders due to known physiological conditions
F10-F19	Mental and behavioral disorders due to psychoactive substance use
F20-F29	Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders
F60-F69	Disorders of adult personality and behavior
F70-F79	Intellectual disabilities

Exclusion: Any kind of psychological counselling, cognitive/ family/ group/ behaviors/ palliative therapy or psychotherapy shall not be covered.

3.12 **COVERAGE FOR MODERN TREATMENTS OR PROCEDURES:** The following procedures will be covered (wherever medically indicated) either as in patient or as part of day care treatment in a hospital up to the limit specified against each procedure during the policy period.

S. No	Treatment or Procedure	Limit (Per Policy Period) for Sum insured bands of 5/10/15 Lakhs
3.12.1	Uterine Artery Embolization and HIFU (High intensity focused ultrasound)	Upto Rs. 1 L
3.12.2	Balloon Sinuplasty	Upto Rs. 1 L
3.12.3	Deep Brain stimulation	Upto Rs. 2 L
3.12.4	Oral chemotherapy	Upto Rs.50K
3.12.5	Immunotherapy- Monoclonal Antibody to be given as injection	Upto Rs 1 L
3.12.6	Intravitreal injections	Upto Rs. 75K
3.12.7	Robotic surgeries	Upto Rs. 2 L
3.12.8	Stereotactic radio surgeries	Upto Rs. 2 L
3.12.9	Bronchial Thermoplasty	Upto Rs. 1 L
3.12.10	Vaporisation of the prostrate (Green laser treatment or holmium laser treatment)	Upto Rs. 1 L
3.12.11	IONM - (Intra Operative Neuro Monitoring)	Upto Rs.30K
3.12.12	Stem cell therapy: Hematopoietic stem cells for bone marrow transplant for haematological conditions to be covered	Upto Rs. 1.5 L

*(L denotes Lakhs)

3.13 **COST OF HEALTH CHECK-UP-** The Insured Person(s) shall be entitled for reimbursement of the cost of medical check-up at the end of a block of every two Claim Free Years. Such payment shall be restricted to the limits mentioned below.

Sum Insured Bands in Rs.	Charges payable
5 lakhs, 10 lakhs & 15 lakhs	Up to a maximum of Rs. 3,500
25 lakhs	Up to a maximum of Rs. 5,000

Note:

a) Any payment made under this clause shall not be treated as a Claim.

b) The unutilized amount under this benefit will not be carried forward.

c) In case the Policy is issued on an Individual Sum Insured basis, the above limits shall be available individually to the Insured Persons. In case the Policy is on Floater Sum Insured basis, the above limits shall be available to all Insured persons on a Floater basis.

3.14 **MEDICAL SECOND OPINION**

In case of any Insured Person requires to undergo Surgery for any of the Critical Illnesses defined under section 2.9 of the Policy Clause, Consultation Expenses incurred on Medical Second Opinion shall be reimbursed as per the limits mentioned below.

Sum Insured Bands in Rs.	Charges payable
5 lakhs, 10 lakhs & 15 lakhs	Up to a maximum of Rs. 5,000
25 lakhs	Up to a maximum of Rs. 7,500

Note: In case the Policy is issued on an Individual Sum Insured basis, the above limits shall be available individually to the Insured Persons. In case the Policy is on Floater Sum Insured basis, the above limits shall be available to all Insured persons on a Floater basis.

3.15 **COVERAGE FOR AYUSH TREATMENT**

Expenses incurred for Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy system of medicines is covered up to 100% of the Sum Insured during each policy year as specified in the policy schedule.

3.16 **NEW BORN BABY COVERAGE**

Hospitalisation Expenses incurred for a New Born Baby are covered for any Illness or Injury from the date of birth till the expiry of this Policy, within the Sum Insured of the mother.

However, expenses incurred towards post-natal care, pre-term or pre-mature care shall not be covered.

Coverage for the New Born Baby would be available during subsequent renewals provided the child is declared for insurance and premium is paid for the child and covered as an Insured Person.

3.17 **AIR AMBULANCE CHARGES**

We will pay the charges incurred towards Air Ambulance Services Reasonably incurred for shifting any Insured Person to Hospital for admission, or from one Hospital to another Hospital for Any One Illness as per the limits given below.

Sum Insured Bands in Rs.	Charges payable
5 lakhs, 10 lakhs & 15 lakhs	Up to a maximum of Rs. 50,000
25 lakhs	Up to a maximum of Rs. 75,000

3.18 **MATERNITY COVERAGE**

A. Our maximum liability for towards Maternity Expenses is as follow:

Sum Insured	Single baby	Twin Babies
5/10/15/25 Lakhs	25000	37500

SPECIAL CONDITIONS APPLICABLE TO MATERNITY:

i. These benefits are admissible only if the expenses are incurred in Hospital as in patient in India.

ii. Our liability under this section shall be limited to two claims paid or admissible under this Policy.

Note: Clause 4.4.15 “Maternity Expenses (Code - Excl18)” under Permanent Exclusions stands modified to the extent covered under this Benefit.

3.19 **INFERTILITY TREATMENT**

We shall provide expenses necessarily incurred for treatment of Infertility (including OPD Treatment) as per limits mentioned below. This limit shall be the lifetime limit in respect of all Insured Persons.

Sum Insured	Amount payable
5 lakhs, 10 lakhs & 15 lakhs	Up to a maximum of Rs. 50,000
25 lakhs	Up to a maximum of Rs. 75,000

Any payment under this Clause shall be paid after the Insured Person has Continuous Coverage of **twenty-four months** under this Plan.

Note: Clause 4.4.14 “Sterility and Infertility (Code- Excl17)” under Permanent Exclusions stands modified to the extent covered under the clause.

3.20 **WELL BABY COVER**

A. **Pre-Mature / Pre-Term Baby:** We will reimburse the Medical Expenses incurred towards hospitalisation of pre-term or pre-mature Baby born within 32 weeks of Gestation Period requiring a minimum period of 24 Hours hospitalization in neo-natal care immediately after birth.

Sum Insured	Limit
5 L, 10 L & 15 L	Rs. 30,000
25 L	Rs. 40,000

Conditions:

1. Pre-Mature/Pre-Term baby, under this policy is a Baby born within 32 weeks of Gestation period.
2. Minimum period of 24-hour hospitalisation is required in neo-natal care immediately after birth.

B. **Vaccination Expenses:** We will also cover Immunization or Vaccination expenses incurred for the New Born Baby up to the age of 2 years and shall be covered up to 0.1% of Sum Insured per policy period.

Note 1: This coverage is available for a New Born Baby born during the Policy Period to a female Insured Person, who has twenty-four months of Continuous Coverage with Us.

Note 2: Clause 4.4.28 “Vaccination and/or inoculation” under Permanent Exclusions

stands modified to the extent covered under this Benefit.

3.21 **BIRTH RIGHT BENEFIT**

If during the Policy Period, Child or New Born Baby covered under the policy is diagnosed to suffer from any of the Disorders mentioned below, a lump sum amount as mentioned below shall be payable subject to the following conditions.

Sum Insured Bands in Rs.	Benefit Payable
5 lakhs, 10 lakhs & 15 lakhs	Rs. 30,000
25 lakhs	Rs.40,000

CONDITIONS:

Disorder	Detection
Autism Spectrum Disorders	Detected between the age of 0-6 Y.
Cerebral Palsy	Detected between the age of 0-4 Y.
Downs Syndrome	Detected between the age of 0-4 Y.

- This Benefit shall be payable on continuous coverage of 24 months under this Plan. However, this is not applicable for New Born Baby born during the Policy Period to a female Insured Person, who has twenty-four months of Continuous Coverage with Us.
- Birth Right Benefit is payable only once in the Lifetime of the Child.
- Any payment under this Clause would be in addition to the Sum Insured and shall not deplete the Sum Insured.
- The Disorder must be supported by Certifying Authorities, as specified in the Rights of the Persons with Disabilities Act, 2016 (49 of 2016), and/or treating doctor's certificate regarding duration Disorder, clinical radiological histological, pathological, histo-pathological and laboratory evidence acceptable to the Company.
- The benefit shall be payable to the Insured provided the Disorder is diagnosed after the first inception of Policy.

4. EXCLUSIONS

No claim will be payable under this Policy for the following:

STANDARD EXCLUSIONS

4.1 **EXCLUSIONS**

The Company shall not be liable to make any payment under the policy, in respect of any expenses incurred in connection with or in respect of:

4.1.1 **INVESTIGATION AND EVALUATION (Code- Excl04)**

a. Expenses related to any admission primarily for diagnostics and evaluation purposes.

b. Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment

4.1.2 **REST CURE, REHABILITATION AND RESPITE CARE (Code- Excl05)**

Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:

a. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.

b. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.

4.1.3 **OBESITY/ WEIGHT CONTROL (Code- Excl06)**

Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:

a. Surgery to be conducted is upon the advice of the Doctor

b. The surgery/Procedure conducted should be supported by clinical protocols

c. The member has to be 18 years of age or older and

d. Body Mass Index (BMI);

1. greater than or equal to 40 or

2. greater than or equal to 35 in conjunction with any of the following severe co- morbidities following failure of less invasive methods of weight loss:

2.i. Obesity-related cardiomyopathy

2.ii. Coronary heart disease

2.iii. Severe Sleep Apnea

2.iv. Uncontrolled Type2 Diabetes

Note: This cover if admissible will carry a waiting period of 24 months from date of inception with us. Bariatric surgery/treatment performed for cosmetic reasons is excluded

4.1.4 **CHANGE-OF-GENDER TREATMENTS (Code- Excl07)**

Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.

4.1.5 **COSMETIC OR PLASTIC SURGERY (Code- Excl08)**

Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.

4.1.6 **HAZARDOUS OR ADVENTURE SPORTS (Code- Excl09)**

Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.

4.1.7 **BREACH OF LAW (Code- Excl10)**

Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.

4.1.8 **EXCLUDED PROVIDERS (Code-Excl11)**

Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the policyholders are not admissible. However, in case of life-threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.

4.1.9 Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof. **(Code- Excl12)**

4.1.10 Treatments received in health hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic

reasons. **(Code- Excl13)**

4.1.11 Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure. **(Code- Excl14)**

4.1.12 **REFRACTIVE ERROR (Code- Excl15)**

Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 diopters.

4.1.13 **UNPROVEN TREATMENTS (Code- Excl16)**

Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.

4.1.14 Acupressure, acupuncture, magnetic therapies.

4.1.15 Any expenses incurred on Domiciliary Hospitalization.

4.1.16 Service charges, Surcharges, Luxury Tax, Admission fees, Registration fees, Record Charges and Telephone Charges levied by the Hospital.

4.1.17 Bodily Injury or Illness due to intentional self-inflicted Injury and attempted suicide.

4.1.18 Circumcision unless Medically Necessary or as may be necessitated due to an Accident.

4.1.19 Convalescence and General debility.

4.1.20 Cost of braces, equipment or external prosthetic devices, eyeglasses, cost of spectacles and contact lenses, hearing aids including cochlear implants.

4.1.21 External Medical / Non-medical equipment used for diagnosis and/or treatment including CPAP/BIPAP, Oxygen Concentrator, Infusion pump , Ambulatory devices (walker, crutches, Collars, Caps, Splints, Elasto crepe bandages, external orthopaedic pads) and sub cutaneous insulin pump, Diabetic foot wear, Glucometer / Thermometer and equipment, which is subsequently used at home and outlives the use and life of the Insured Person.

4.1.22 Nuclear, chemical or biological attack or weapons, contributed to, caused by, resulting from or from any other cause or event contributing concurrently or in any other sequence to the loss, claim or expense. For the purpose of this exclusion:

a. Nuclear attack or weapons means the use of any nuclear weapon or device or waste or combustion of nuclear fuel or the emission, discharge, dispersal, release or escape of fissile/ fusion material emitting a level of radioactivity capable of causing any Illness, incapacitating disablement or death.

b. Chemical attack or weapons means the emission, discharge, dispersal, release or escape of any solid, liquid or gaseous chemical compound which, when suitably distributed, is capable of causing any Illness, incapacitating disablement or death.

c. Biological attack or weapons means the emission, discharge, dispersal, release or escape of any pathogenic (disease producing) micro-organisms and/or biologically produced toxins (including genetically modified organisms and chemically synthesized toxins) which are capable of causing any Illness, incapacitating disablement or death.

4.1.23 Stem cell implantation/Surgery for other than those treatments mentioned in clause 3.12.12

4.1.24 Expenses incurred for Rotational Field Quantum Magnetic Resonance (RFQMR), External Counter Pulsation (ECP), Enhanced External Counter Pulsation (EECP), Hyperbaric Oxygen Therapy.

4.1.25 Treatment taken outside the geographical limits of India

4.1.26 Vaccination and/or inoculation

4.1.27 War (whether declared or not) and war like occurrence or invasion, acts of foreign enemies, hostilities, civil war, rebellion, revolutions, insurrections, mutiny, military or usurped power, seizure, capture, arrest, restraints and detainment of all kinds.

4.1.28 Procedures/treatments usually done in outpatient department are not payable under the Policy even if converted as an in-patient in the Hospital for more than 24 hours.

4.1.29 Change of treatment from one system to another unless recommended by the consultant/ Hospital under which the treatment is taken.]

5. GENERAL TERMS AND CLAUSES

STANDARD GENERAL TERMS AND CLAUSES

5.1 **CANCELLATION**

The policyholder may cancel his/her policy at any time during the term, by giving 7 days' notice in writing. The Insurer shall

a. refunds proportionate premium for unexpired policy period, if the term of policy up to one year and there is no claim (s) made during the policy period.

b. refund premium for the unexpired policy period, in respect of policies with term more than 1 year and risk coverage for such policy years has not commenced

Not with standing anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the insured person under the policy.

The Company may cancel the policy at any time on grounds of misrepresentation non-disclosure of material facts, fraud by the insured person by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non- disclosure of material facts or fraud.

5.2 **CONDITION PRECEDENT TO ADMISSION OF LIABILITY:**

The terms and conditions of the policy must be fulfilled by the insured person for the Company to make any payment for claim(s) arising under the policy.

5.3 **COMPLETE DISCHARGE**

Any payment to the policyholder, insured person or his/ her nominees or his/ her legal representative or assignee or to the Hospital, as the case may be, for any benefit under the policy shall be a valid discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

5.4 **DISCLOSURE OF INFORMATION**

The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis description or non-disclosure of any material fact by the policyholder.

(Explanation: "Material facts" for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk).

5.5 **FRAUD**

If any claim made by the insured person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the insured person or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy and the premium paid shall be forfeited.

Any amount already paid against claims made under this policy but which are found fraudulent later shall be repaid by all recipient(s)/policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment to the insurer.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the insured person or by his agent or the hospital/doctor/any other party acting on behalf of the insured person, with intent to deceive the insurer or to induce the insurer to issue an insurance policy:

i. the suggestion, as a fact of that which is not true and which the insured person does not believe to be true;

ii. the active concealment of a fact by the insured person having knowledge or belief of the fact;

iii. any other act fitted to deceive; and

iv. any such act or omission as the law specially declares to be fraudulent

The Company shall not repudiate the claim and / or forfeit the policy benefits on the ground of Fraud, if the insured person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of the insurer.

However, expenses incurred towards post-natal care, pre-term or pre-mature care shall not be covered.

Coverage for the New Born Baby would be available during subsequent renewals provided the child is declared for insurance and premium is paid for the child and covered as an Insured Person.

1. **Indemnity Policies:**

a) If a policyholder has more than one health insurance policy from different insurers he/she can file for claim settlement as per his/her choice under any policy.

b) The Insurer of that chosen policy shall be treated as the primary Insurer.

In case the available coverage under the said policy is less than the admissible claim amount, the primary Insurer shall seek the details of other available policies of the policyholder, his/her choice of the other insurer(s) and shall coordinate with other Insurers to ensure settlement of the balance amount as per the policy conditions, without causing any hassles to the policyholder.

2. **Benefit based Policies**:

On occurrence of the insured event the policyholder, can claim from all Insurers under all policies**.**

Note: The Insured Person must disclose such other Insurance at the time of making a claim under this Policy.

5.6 **MORATORIUM PERIOD**

After completion of sixty continuous months of coverage (including portability and migration in health insurance policy), no policy and claim shall be contestable by the insurer on grounds of non-disclosure, mis-representation except on grounds of established fraud. This period of sixty continuous months is called as Moratorium period. The moratorium would be applicable for the sums insured of the first policy. Wherever, the sum insured is enhanced, completion of sixty continuous months would be applicable from the date of enhancement of sums insured only on the enhanced limit.

5.7 **NOMINATION:**

The policyholder is required at the inception of the policy to make a nomination. In the event of death of the policyholder, the claim proceeds will be paid to the nominee. Nomination can be changed at any time during the term of the policy. Any change of nomination shall be communicated to the company in writing and such change shall be effective only when an endorsement on the policy is made and in case there is no subsisting nominee, the legal heirs or legal representatives of the policyholder whose discharge shall be treated as full and final discharge of its liability under the policy.

5.8 **RENEWAL OF POLICY**

The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person.

i. The Company shall give notice for renewal 30 days' advance from the due date.

ii. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.

iii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.

iv. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the Grace Period.

v. No loading shall apply on renewals based on individual claims experience.

5.9 **REDRESSAL OF GRIEVANCE**

In case of any grievance the insured person may contact the company through

Website : https://www.newindia.co.in/portal/readMore/Grievances

Toll free: 1800-209-1415

E-mail, Fax and Courier: As mentioned in the above address

Senior Citizens may write to seniorcitizencare.ho@newindia.co.in

Insured person may also approach the grievance cell at any of the company's branches with the details of grievance.

If Insured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at https://www.newindia.co.in/portal/readMore/Grievances For updated details of grievance officer, kindly refer the link https://www.newindia.co.in/portal/readMore/Grievances

If Insured person is not satisfied with the redressal of grievance through above methods, the insured person may also approach the office of Insurance Ombudsman of the respective

area/region for redressal of grievance as per lnsurance Ombudsman Rules 2017. Please refer to Annexure III.

Grievance may also be lodged at IRDAI integrated Grievance Management System - https://igms.irdai.gov.in

SPECIFIC TERMS AND CLAUSES

5.10 **BASIS OF INSURANCE:**

This Policy is issued on the basis of the truth and accuracy of statements in the Proposal. If there is any misrepresentation or non-disclosure, we will be entitled to treat the Policy as void.

5.11 **PREMIUM:**

Unless premium is paid before commencement of risk, this Policy shall have no effect.

5.12 **PLACE OF TREATMENT AND PAYMENT:**

This Policy covers medical/surgical treatment and/or services rendered only in India. Admissible claims shall be payable only in Indian Rupees.

Payment shall be made directly to Network Hospital if Cashless facility is applied for before treatment and accepted by TPA. If request for Cashless facility is not accepted by TPA, bills shall be submitted to the TPA after payment of Hospital bills by you.

Note: Cashless facility is only a mode of claim payment and cannot be demanded in every claim. If we/TPA have doubts regarding admissibility of a claim at the initial stage, which cannot be decided without further verification of treatment records, request for Cashless facility may be declined. Such decision by TPA or Us shall be final. Denial of Cashless facility would not imply denial of claim. If Cashless facility is denied, you may submit the papers on completion of treatment and admissibility of the claim would be subject to the terms, conditions and exceptions of the Policy.

5.13 **COMMUNICATION:**

You must send all communications and papers regarding a claim to the TPA at the address shown in the Schedule. For all other matters relating to the policy, communication must be sent to our Policy issuing office. Communications you wish to rely upon must be in writing.

5.14 **NOTICE OF CLAIM:**

If You intend to make any claim under this Policy You must:

a. Intimate TPA in writing on detection of any Illness/Injury being suffered immediately or forty-eight hours before Hospitalisation.

b. Intimate within twenty-four hours from the time of Hospitalisation in case of Hospitalisation due to medical emergency.

c. Submit following supporting documents TPA relating to the claim within seven days from the date of discharge from the Hospital:

   i. Bill, Receipt and Discharge certificate / card from the Hospital.

   ii. Cash Memos from the Hospitals (s) / Chemists (s), supported by proper prescriptions.

   iii. Receipt and Pathological test reports from Pathologist supported by the note from the attending Medical Practitioner / Surgeon recommending such Pathological tests
   / pathological.

iv. Surgeon's certificate stating nature of operation performed and Surgeons' bill and receipt.

v. Attending Doctor's/ Consultant's/ Specialist's / Anesthetist's bill and receipt, and certificate regarding diagnosis.

d. In case of post-Hospitalisation treatment (limited to sixty days), submit all claim documents within 15 days after completion of such treatment.

e. Provide TPA with authorization to obtain medical and other records from any Hospital, Laboratory or other agency.

Note: The above stipulations are not intended merely to prejudice Your claims, but their compliance is of utmost importance and necessity for Us to identify and verify all facts and surrounding circumstances relating to a claim and determine whether it is payable.

Waiver of delay may be considered in extreme cases of hardship, but only if it is proved to Our satisfaction, it was not possible for You or any other person to comply with the prescribed time-limit.

5.15 **SETTLEMENT/REJECTION OF CLAIM:**

i. We shall settle or reject a claim, as may be the case, within fifteen days of the receipt of the last 'necessary' document.

ii. While efforts will be made by Us to not call for any document not listed in Clause 5.20, where any additional document or clarification is necessary to take a decision on the claim, such additional documents will be called for.

iii. All necessary claim documents pertaining to Hospitalization should be furnished by the Insured Person in original to the TPA (as mentioned in the Schedule), within fifteen days from the date of discharge from the Hospital. However, claims filed even beyond such period will be considered if there are valid reasons for delay in submission.

a. In case of any deficiency in submission of documents, the TPA shall issue a deficiency request.

b. In case of non-submission of documents requested in the deficiency request within seven days from the date of receipt of the deficiency request, three reminders shall be sent by the TPA at an interval of seven days each.

c. The claim shall stand repudiated if the documents, mandatory for taking the decision of admissibility of the Claim, are not submitted within seven days of the third reminder.

d. If the required documents are such that it does not affect the admissibility of the claim and is limited to payment of certain expenditure only, the Claim will be paid after reducing such amount from the admissible amount.

e. In the event of a claim lodged under the Policy and the original documents having been submitted to any other insurer, the Company shall accept the copy of the documents and claim settlement advice, duly certified by the other insurer.

5.16 The Insured person shall submit to the TPA all original bills, receipts and other documents upon which a claim is based and shall also give the TPA/Us such additional information and assistance as the TPA / We may require.

5.17 Any Medical Practitioner authorised by the TPA/Us shall be allowed to examine the Insured Person, at our cost, if We deem Medically Necessary in connection with any claim.

ANNEXURE I: LIST OF DAY CARE PROCEDURES:

No	LIST OF DAY-CARE TREATMENTS	No	LIST OF DAY-CARE TREATMENTS
	ENT		**General Surgery**
1	Stapedotomy	148	Infected keloid excision
2	Myringoplasty(Type I Tympanoplasty)	149	Incision of a pilonidal sinus / abscess
3	Revision stapedectomy	150	Infected sebaceous cyst
4	Labyrinthectomy for severe Vertigo	151	Infected lipoma excision
5	Stapedectomy under GA	152	Maximal anal dilatation
6	Ossiculoplasty	153	Surgical Treatment Of Haemorrhoids
7	Myringotomy with Grommet Insertion	154	Liver Abscess- catheter drainage
8	Tympanoplasty (Type III)	155	Fissure in Ano- fissurectomy
9	Stapedectomy under LA	156	Fibroadenoma breast excision
10	Revision of the fenestration of the inner ear.	157	Oesophageal varices Sclerotherapy
11	Tympanoplasty (Type IV)	158	ERCP – pancreatic duct stone removal
12	Endolymphatic Sac Surgery for Meniere's Disease	159	Perianal abscess I&D
13	Turbinectomy	160	Perianal hematoma Evacuation
14	Removal of Tympanic Drain under LA	161	Fissure in ano sphincterotomy
15	Endoscopic Stapedectomy	162	UGI scopy and Polypectomy oesophagus
16	Fenestration of the inner ear	163	Breast abscess I& D
17	Incision and drainage of perichondritis	164	Feeding Gastrostomy
18	Septoplasty	165	Oesophagoscopy and biopsy of growth

			oesophagus
19	Vestibular Nerve section	166	ERCP – Bile duct stone removal
20	Thyroplasty Type I	167	Ileostomy closure
21	Tympanoplasty (Type II)	168	Polypectomy colon
22	Reduction of fracture of Nasal Bone	169	Splenic abscesses Laparoscopic Drainage
23	Excision and destruction of lingual tonsils	170	UGI SCOPY and Polypectomy stomach
24	Conchoplasty	171	Rigid Oesophagoscopy for FB removal
25	Thyroplasty Type II	172	Feeding Jejunostomy
26	Tracheostomy	173	Colostomy
27	Excision of Angioma Septum	174	Ileostomy
28	Turbinoplasty	175	Colostomy closure
29	Incision & Drainage of Retro Pharyngeal Abscess	176	Submandibular salivary duct stone removal
30	Uvulo Palato Pharyngo Plasty	177	Pancreatic Pseudocysts Endoscopic Drainage
31	Palatoplasty	178	Subcutaneous mastectomy
32	Tonsillectomy without adenoidectomy	179	Excision of Ranula under GA
33	Adenoidectomy with Grommet insertion	180	Rigid Oesophagoscopy for dilation of benign Strictures
34	Adenoidectomy without Grommet insertion	181	Eversion of Sac
35	Vocal Cord lateralisation Procedure	182	1. a) Unilateral
36	Incision & Drainage of Para Pharyngeal Abscess	183	b)Bilateral
37	Transoral incision and drainage of a pharyngeal abscess	184	Lord’s plication
38	Tonsillectomy with adenoidectomy	185	Jaboulay’s Procedure
39	Tracheoplasty	186	Scrotoplasty
40	Reconstruction Of The Middle Ear	187	Surgical treatment of varicocele
41	Mastoidectomy	188	Epididymectomy
42	Excision And Destruction Of Diseased Tissue Of The Nose	189	Circumcision for Trauma
43	Incision (Opening) And Destruction (Elimination) Of The Inner Ear	190	Meatoplasty
44	Incision Of The Mastoid Process And Middle Ear	191	Intersphincteric abscess incision and drainage
45	Nasal Sinus Aspiration	192	Psoas Abscess Incision and Drainage
46	Other Microsurgical Operations On The Middle Ear	193	Thyroid abscess Incision and Drainage
47	Other Operations On The Auditory Ossicles	194	TIPS procedure for portal hypertension
48	Plastic Surgery To The Floor Of The Mouth	195	PAIR Procedure of Hydatid Cyst liver
49	Incision Of The Hard And Soft Palate	196	Excision of Cervical RIB

50	External Incision And Drainage In The Region Of The Mouth, Jaw And Face	197	Surgery for fracture Penis
51	Other Operations On The Salivary Glands And Salivary Ducts	198	Parastomal hernia
	Ophthalmology	199	Revision colostomy
52	Incision of tear glands	200	Prolapsed colostomy- Correction
53	Other operation on the tear ducts	201	Laparoscopic cardiomyotomy (Hellers)
54	Incision of diseased eyelids	202	Laparoscopic pyloromyotomy (Ramstedt)
55	Excision and destruction of the diseased tissue of the eyelid	203	Orchiectomy
56	Removal of foreign body from the lens of the eye.	204	Incision Of The Breast
57	Corrective surgery of the entropion and ectropion	205	Operations On The Nipple
58	Operations for pterygium	206	Incision And Excision Of Tissue In The Perianal Region
59	Corrective surgery of blepharoptosis	207	Surgical Treatment Of Anal Fistulas
60	Removal of foreign body from conjunctiva	208	Division Of The Anal Sphincter (Sphincterotomy)
61	Removal of Foreign body from cornea	209	Glossectomy
62	Incision of the cornea	210	Reconstruction Of The Tongue
63	Other operations on the cornea	211	Incision, Excision And Destruction Of Diseased Tissue Of The Tongue
64	Operation on the canthus and epicanthus	212	Operations On The Seminal Vesicles
65	Removal of foreign body from the orbit and the eye ball.	213	Other Operations On The Spermatic Cord, Epididymis And Ductus Deferens
66	Surgery for cataract	214	Local Excision And Destruction Of Diseased Tissue Of The Penis
67	Treatment of retinal lesion	215	Other Operations On The Penis
68	Removal of foreign body from the posterior chamber of the eye	216	Other Excisions Of The Skin And Subcutaneous Tissues
	Oncology	217	Other Incisions Of The Skin And Subcutaneous Tissues
69	IV Push Chemotherapy	218	Simple Restoration Of Surface Continuity Of The Skin And Subcutaneous Tissues
70	Continuous Infusional Chemotherapy	219	Free Skin Transplantation, Donor Site
71	Infusional Chemotherapy	220	Free Skin Transplantation, Recipient Site
72	CCRT-Concurrent Chemo + RT	221	Reconstruction Of The Testis
73	SRS- Stereotactic radiosurgery	222	Incision Of The Scrotum And Tunica Vaginalis Testis
74	TBI- Total Body Radiotherapy	223	Excision In The Area Of The Epididymis

75	Adjuvant Radiotherapy	224	Revision Of Skin Plasty

76	Radical chemotherapy	225	Other Restoration And Reconstruction Of The Skin And Subcutaneous Tissues
77	Neoadjuvant radiotherapy	226	Destruction Of Diseased Tissue In The Skin And Subcutaneous Tissues
78	Palliative Radiotherapy		**Orthopedics**
79	Radical Radiotherapy	227	Arthroscopic Repair of ACL tear knee
80	Palliative chemotherapy	228	Arthroscopic repair of PCL tear knee
81	Neoadjuvant chemotherapy	229	Tendon shortening
82	Adjuvant chemotherapy	230	Arthroscopic Meniscectomy – Knee
83	Induction chemotherapy	231	Treatment of clavicle dislocation
84	Consolidation chemotherapy	232	Arthroscopic meniscus repair
85	Maintenance chemotherapy	233	Haemarthrosis knee- lavage
	Urology	234	Abscess knee joint drainage
86	AV fistula	235	Repair of knee cap tendon
87	URSL with stenting	236	ORIF with K wire fixation- small bones
88	URSL with lithotripsy	237	ORIF with plating- Small long bones
89	ESWL	238	Arthrotomy Hip joint
90	Haemodialysis	239	Syme’s amputation
91	Cystoscopy and removal of polyp	240	Arthroplasty
92	Excision of urethral diverticulum	241	Partial removal of rib
93	Removal of urethral Stone	242	Treatment of sesamoid bone fracture
94	Ureter endoscopy and treatment	243	Amputation of metacarpal bone
95	Surgery for pelvi ureteric junction obstruction	244	Repair / graft of foot tendon
96	Injury prepuce- circumcision	245	Revision/Removal of Knee cap
97	Frenular tear repair	246	Remove/graft leg bone lesion
98	Meatotomy for meatal stenosis	247	Repair/graft achilles tendon
99	Surgery for fournier’s gangrene scrotum	248	Biopsy elbow joint lining
100	Surgery filarial scrotum	249	Biopsy finger joint lining
101	Surgery for watering can perineum	250	Tendon lengthening
102	Repair of penile torsion	251	Surgery of bunion
103	Drainage of prostate abscess	252	Tendon transfer procedure
104	Cystoscopy and removal of FB	253	Removal of knee cap bursa
105	Transurethral Excision And Destruction Of Prostate Tissue	254	Treatment of fracture of ulna
106	Transurethral And Percutaneous Destruction Of Prostate Tissue	255	Treatment of scapula fracture
107	Open Surgical Excision And Destruction Of Prostate Tissue	256	Removal of tumor of arm/ elbow under RA/GA
108	Radical Prostatovesiculectomy	257	Repair of ruptured tendon
109	Other Excision And Destruction Of	258	Revision of neck muscle (Torticollis

	Prostate Tissue		release)
110	Incision Of The Prostate	259	Treatment fracture of radius & ulna
111	Incision And Excision Of Periprostatic Tissue	260	Incision On Bone, Septic And Aseptic
112	Other Operations On The Prostate	261	Closed Reduction On Fracture, Luxation Or Epiphyseolysis With Osteosynthesis
	Gynaecology	262	Reduction Of Dislocation Under Ga
113	Hysteroscopic removal of myoma		**Paediatric surgery**
114	D&C	263	Vaginoplasty
115	Hysteroscopic resection of septum	264	Dilatation of accidental caustic stricture oesophageal
116	Hysteroscopic adhesiolysis	265	Presacral Teratomas Excision
117	Polypectomy Endometrium	266	Removal of vesical stone
118	Hysteroscopic resection of fibroid	267	Excision Sigmoid Polyp
119	LLETZ	268	Sternomastoid Tenotomy
120	Conization	269	High Orchidectomy for testis tumours
121	Polypectomy cervix	270	Excision of cervical teratoma
122	Hysteroscopic resection of endometrial polyp	271	Rectal-Myomectomy
123	Vulval wart excision	272	Rectal prolapse (Delorme's procedure)
124	Laparoscopic paraovarian cyst excision	273	Orchidopexy for undescended testis
125	Uterine artery embolization	274	Detorsion of torsion Testis
126	Bartholin Cyst excision	275	Lap.Abdominal exploration in cryptorchidism
127	Laparoscopic cystectomy	276	EUA + biopsy multiple fistula in ano
128	Endometrial ablation	277	Excision of fistula-in-ano
129	Vaginal wall cyst excision		**Others**
130	Vulval cyst Excision	278	Coronary Angiography
131	Laparoscopic paratubal cyst excision	279	Ultrasound Guided Aspirations
132	Hysteroscopy, removal of myoma	280	Chemosurgery To The Skin
133	TURBT		
134	Laparoscopic Myomectomy		
135	Surgery for SUI		
136	Pelvic floor repair (excluding Fistula repair)		
137	Laparoscopic oophorectomy		
138	Incision Of The Ovary		
139	Insufflation Of The Fallopian Tubes		
140	Dilatation Of The Cervical Canal		
141	Conisation Of The Uterine Cervix		
142	Hysterotomy		
143	Therapeutic Curettage		

144	Culdotomy		
145	Incision Of The Vagina		
146	Local Excision And Destruction Of Diseased Tissue Of The Vagina And The Pouch Of Douglas		
147	Incision Of The Vulva		

ANNEXURE II:

List I – Items for which coverage is not available in the policy

S. No.	ITEM
1	BABY FOOD
2	BABY UTILITIES CHARGES
3	BEAUTY SERVICES
4	BELTS/ BRACES
5	BUDS
6	COLD PACK/HOT PACK
7	CARRY BAGS
8	EMAIL / INTERNET CHARGES
9	FOOD CHARGES (OTHER THAN PATIENT's DIET PROVIDED BY HOSPITAL)
10	LEGGINGS
11	LAUNDRY CHARGES
12	MINERAL WATER
13	SANITARY PAD
14	TELEPHONE CHARGES
15	GUEST SERVICES
16	CREPE BANDAGE
17	DIAPER OF ANY TYPE
18	EYELET COLLAR
19	SLINGS
20	BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES
21	SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED
22	Television Charges
23	SURCHARGES
24	ATTENDANT CHARGES
25	EXTRA DIET OF PATIENT (OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)
26	BIRTH CERTIFICATE
27	CERTIFICATE CHARGES
28	COURIER CHARGES
29	CONVEYANCE CHARGES
30	MEDICAL CERTIFICATE
31	MEDICAL RECORDS
32	PHOTOCOPIES CHARGES
33	MORTUARY CHARGES
34	WALKING AIDS CHARGES
35	OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)
36	SPACER

37	SPIROMETRE
38	NEBULIZER KIT
39	STEAM INHALER
40	ARMSLING
41	THERMOMETER
42	CERVICAL COLLAR
43	SPLINT
44	DIABETIC FOOT WEAR
45	KNEE BRACES (LONG/ SHORT/ HINGED)
46	KNEE IMMOBILIZER/SHOULDER IMMOBILIZER
47	LUMBO SACRAL BELT
48	NIMBUS BED OR WATER OR AIR BED CHARGES
49	AMBULANCE COLLAR
50	AMBULANCE EQUIPMENT
51	ABDOMINAL BINDER
52	PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES
53	SUGAR FREE Tablets
54	CREAMS POWDERS LOTIONS (Toiletries are not payable, only prescribed medical pharmaceuticals payable)
55	ECG ELECTRODES
56	GLOVES
57	NEBULISATION KIT
58	ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]
59	KIDNEY TRAY
60	MASK
61	OUNCE GLASS
62	OXYGEN MASK
63	PELVIC TRACTION BELT
64	PAN CAN
65	TROLLY COVER
66	UROMETER, URINE JUG
67	AMBULANCE
68	VASOFIX SAFETY

List II – Items that are to be subsumed into Room Charges

S. No.	ITEM
1	BABY CHARGES (UNLESS SPECIFIED/INDICATED)
2	HAND WASH
3	SHOE COVER
4	CAPS
5	CRADLE CHARGES
6	COMB
7	EAU-DE-COLOGNE / ROOM FRESHNERS
8	FOOT COVER
9	GOWN
10	SLIPPERS
11	TISSUE PAPER
12	TOOTH PASTE
13	TOOTH BRUSH
14	BED PAN
15	FACE MASK
16	FLEXI MASK
17	HAND HOLDER
18	SPUTUM CUP
19	DISINFECTANT LOTIONS
20	LUXURY TAX
21	HVAC
22	HOUSE KEEPING CHARGES
23	AIR CONDITIONER CHARGES
24	IM IV INJECTION CHARGES
25	CLEAN SHEET
26	BLANKET/WARMER BLANKET
27	ADMISSION KIT
28	DIABETIC CHART CHARGES
29	DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES
30	DISCHARGE PROCEDURE CHARGES
31	DAILY CHART CHARGES
32	ENTRANCE PASS / VISITORS PASS CHARGES
33	EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE
34	FILE OPENING CHARGES
35	INCIDENTAL EXPENSES / MISC. CHARGES (NOT EXPLAINED)
36	PATIENT IDENTIFICATION BAND / NAME TAG
37	PULSEOXYMETER CHARGES

List III – Items that are to be subsumed into Procedure Charges

S. No.	ITEM
1	HAIR REMOVAL CREAM
2	DISPOSABLES RAZORS CHARGES (for site preparations)
3	EYE PAD
4	EYE SHEILD
5	CAMERA COVER
6	DVD, CD CHARGES
7	GAUSE SOFT
8	GAUZE
9	WARD AND THEATRE BOOKING CHARGES
10	ARTHROSCOPY AND ENDOSCOPY INSTRUMENTS
11	MICROSCOPE COVER
12	SURGICAL BLADES, HARMONICSCALPEL,SHAVER
13	SURGICAL DRILL
14	EYE KIT
15	EYE DRAPE
16	X-RAY FILM
17	BOYLES APPARATUS CHARGES
18	COTTON
19	COTTON BANDAGE
20	SURGICAL TAPE
21	APRON
22	TORNIQUET
23	ORTHOBUNDLE, GYNAEC BUNDLE

List IV – Items that are to be subsumed into costs of treatment

S. No.	ITEM
1	ADMISSION/REGISTRATION CHARGES
2	HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE
3	URINE CONTAINER
4	BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES
5	BIPAP MACHINE
6	CPAP/ CAPD EQUIPMENTS
7	INFUSION PUMP– COST
8	HYDROGEN PEROXIDE\SPIRIT\ DISINFECTANTS ETC
9	NUTRITION PLANNING CHARGES - DIETICIAN CHARGES- DIET CHARGES
10	HIV KIT
11	ANTISEPTIC MOUTHWASH
12	LOZENGES
13	MOUTH PAINT
14	VACCINATION CHARGES
15	ALCOHOL SWABES
16	SCRUB SOLUTION/STERILLIUM
17	GLUCOMETER & STRIPS
18	URINE BAG

Annexure-III

The contact details of the Insurance Ombudsman offices are as below

The updated details of Insurance Ombudsman are available on :https://www.cioins.co.in/Ombudsman

AHMEDABAD – **Office of the Insurance Ombudsman, Jeevan Prakash Building, 6th floor,** **Tilak Marg, Relief Road, Ahmedabad – 380 001. Tel.: 079 - 25501201/02/05/06** **Email: bimalokpal.ahmedabad@cioins.co.in** **Jurisdiction : Gujarat, Dadra & Nagar Haveli, Daman and Diu.**	BHOPAL - **Office of the Insurance Ombudsman,** **Janak Vihar Complex, 2nd Floor, 6,** **Malviya Nagar, Opp. Airtel Office, Near New Market, Bhopal – 462003.** **Tel.: 0755 - 2769201 / 2769202** **Fax: 0755 - 2769203** **Email: bimalokpal.bhopal@cioins.co.in** **Jurisdiction : Madhya Pradesh, Chhattisgarh.**
BHUBANESHWAR – **Office of the Insurance Ombudsman,** **62, Forest park, Bhubneshwar – 751 009.** **Tel.: 0674 - 2596461 /2596455** **Fax: 0674 - 2596429** **Email: bimalokpal.bhubaneswar@cioins.co.in** **Jurisdiction : Odisha**	CHANDIGARH – **Office of the Insurance Ombudsman,** **S.C.O. No. 101, 102 & 103, 2nd Floor,** **Batra Building, Sector 17 – D, Chandigarh – 160 017.Tel.: 0172 - 2706196 / 2706468** **Fax: 0172 - 2708274** **Email: bimalokpal.chandigarh@cioins.co.in** **Jurisdiction : Punjab, Haryana (excluding Gurugram, Faridabad, Sonepat and Bahadurgarh), Himachal Pradesh, Union Territories of Jammu & Kashmir,Ladakh & Chandigarh.**
CHENNAI – **Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453,** **Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284** **Fax: 044 - 24333664** **Email: bimalokpal.chennai@cioins.co.in** **Jurisdiction : Tamil Nadu, PuducherryTown and Karaikal (which are part of Puducherry).**	DELHI - **Office of the Insurance Ombudsman,** **2/2 A, Universal Insurance Building,** **Asaf Ali Road, New Delhi – 110 002.Tel.: 011 - 23232481/23213504** **Email: bimalokpal.delhi@cioins.co.in** **Jurisdiction : Delhi & following Districts of Haryana - Gurugram, Faridabad, Sonepat & Bahadurgarh.**
GUWAHATI – **Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor,** **Nr. Panbazar over bridge, S.S. Road,** **Guwahati – 781001(ASSAM).** **Tel.: 0361 - 2632204 / 2602205** **Email: bimalokpal.guwahati@cioins.co.in** **Jurisdiction : Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.**	HYDERABAD – **Office of the Insurance Ombudsman,6-2-46, 1st floor, "Moin Court",** **Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool,Hyderabad - 500 004.** **Tel.: 040 - 67504123 / 23312122** **Fax: 040 - 23376599** **Email: bimalokpal.hyderabad@cioins.co.in** **Jurisdiction : Andhra Pradesh, Telangana,**

	Yanam and part of Union Territory of Puducherry.
ERNAKULAM – **Office of the Insurance Ombudsman, 2nd Floor, Pulinat Bldg., Opp. Cochin Shipyard, M. G. Road,Ernakulam - 682 015. Tel.: 0484 - 2358759 / 2359338 Fax: 0484 - 2359336 Email: bimalokpal.ernakulam@cioins.co.in Jurisdiction : Kerala, Lakshadweep, Mahe-a part of Union Territory of Puducherry.**	KOLKATA - **Office of the Insurance Ombudsman, Hindustan Bldg.Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340 Fax : 033 - 22124341 Email: bimalokpal.kolkata@cioins.co.in Jurisdiction : West Bengal, Sikkim, Andaman & Nicobar Islands.**
LUCKNOW - **Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Email: bimalokpal.lucknow@cioins.co.in Jurisdiction : Districts of Uttar Pradesh : Lalitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhabdra, Fatehpur, Pratapgarh, Jaunpur,Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.**	MUMBAI – **Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 69038821/23/24/25/26/27/28/28/29/30/31 Email: bimalokpal.mumbai@cioins.co.in Jurisdiction :** List of wards **under Mumbai Metropolitan Region excluding wards in Mumbai – i.e M/E, M/W, N , S and T covered under Office of Insurance Ombudsman Thane and areas of Navi Mumbai.**
JAIPUR – **Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363 Email: bimalokpal.jaipur@cioins.co.in Jurisdiction : Rajasthan**	PUNE - **Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s. 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune –411 030. Tel.: 020-41312555 Email: bimalokpal.pune@cioins.co.in Jurisdiction : State of Goa and State of Maharashtra excluding areas of Navi Mumbai, Thane district, Palghar District, Raigad district & Mumbai Metropolitan Region**
BENGALURU – **Office of the Insurance Ombudsman, Jeevan Soudha Building,PID No. 57-27-N- 19 Ground Floor, 19/19, 24th Main Road, JP Nagar, Ist Phase, Bengaluru – 560 078.Tel.: 080 - 26652048 / 26652049 Email: bimalokpal.bengaluru@cioins.co.in**	NOIDA – **Office of the Insurance Ombudsman, Bhagwan Sahai Palace, 4th Floor, Main Road, Naya Bans, Sector 15, Distt: Gautam Buddh Nagar, U.P-201301. Tel.: 0120-2514250 / 2514252 / 2514253 Email: bimalokpal.noida@cioins.co.in Jurisdiction : State of Uttarakhand and the**

Jurisdiction :Karnataka.	**following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshehar, Etah, Kannauj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautam Buddh nagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.**
PATNA **-** **Office of the Insurance Ombudsman, 1st Floor,Kalpana Arcade Building,,** **Bazar Samiti Road, Bahadurpur, Patna 800 006. Tel.: 0612-2680952** **Email: bimalokpal.patna@cioins.co.in** **Jurisdiction : Bihar, Jharkhand.**	THANE – **Office of the Insurance Ombudsman, 2nd Floor,Jeevan Chintamani Building,** **Vasantrao Naik Mahamarg,** **Thane (West)** **Thane - 400604** **Email: bimalokpal.thane@cioins.co.in** **Jurisdiction :Area of Navi Mumbai, Thane District, Raigad District, Palghar District and** wards of Mumbai**, M/East, M/West, N, S and T."**

ANNEXURE – IV

Table of Coverages/Procedures with Sub-limits and Waiting Periods	
Nature of Disease/Procedure/Treatment	**Sublimit (Per Policy Period)**
Congenital External Disease (Waiting Period Not Applicable for New Born Baby)	Up to 10% of the average Sum Insured in the preceding 24 months
Artificial life maintenance (This sub limit is applicable only for person who is declared to be in a vegetative state as certified by the treating medical practitioner)	Up to 25% of the Sum Insured and a Maximum of 15 days
Puberty and Menopause related Disorders	Up to 25% of the Sum Insured
Age Related Macular Degeneration (ARMD)	Up to 20% of the Sum Insured
Genetic diseases or disorders	Up to 25% of the Sum Insured
Treatment of Mental Illness (ICD Code: F01-F29 & F60-F79)	Up to 25% of the Sum Insured